Georgia Obstetrical and Gynecological Society, Inc.

OBGyn News

PROMOTING EXCELLENCE IN WOMEN'S HEALTHCARE in GEORGIA

Georgia Section
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Long-Acting Reversible Contraception: Underutilized in Georgia

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Long-acting reversible contraceptive (LARC) methods are becoming more popular in the United States. However, as highlighted in a recent survey of Georgia physicians, LARC use is restricted by financial and other barriers.

According to the Center for Disease Control's National Survey of Family Growth, 5.6% of women using contraception were using a LARC method in 2006-2008, up from 2.4% in 2002. LARCs include IUDs (Paragard, Mirena) and contraceptive implants (Implanon, Nexplanon). In 2006-2008, 98% of LARC users were using an IUD, while 2% were using an implant. LARC methods have a number of advantages:

1. They are highly effective, with typical-use failure rates less than one percent. According to recently-published data from the Contraceptive CHOICE[1] project, women using pills, patches, or rings are 20 times more likely to become pregnant as women choosing an IUD or an implant.
2. As their name implies, they are long-acting and do not require any day-to-day action by the patient.
3. They are reversible, making them an excellent choice for women desiring highly effective and long-term contraception who also wish to have children in the future.
4. They have very few contraindications according to CDC and WHO eligibility criteria. The copper IUD may be a good option for women who have contraindications to hormonal methods. The progestin-releasing IUD and implants may be good options for women who have contraindications to estrogen-containing methods.
5. Progestin-releasing methods can be used for reasons other than contraception, such as treatment of menstrual disorders.

As with any contraceptive method, LARCs do have side effects and may not be the best choice for every patient. However, given their many advantages, it is surprising that they are not used more frequently. Numerous studies have examined barriers to LARC use in the U.S., and some of those barriers were reflected in a recent survey of Georgia physicians.

First, LARC methods have a high up-front cost. If used for an extended period of time, they are actually cheaper than oral contraceptives—but patients or their insurance companies must pay the high initial cost. Contraception is not always covered by private insurance companies, and some insurers may require pre-authorization, creating an administrative barrier.

Second, uncertainty may exist among providers regarding the suitability of IUDs for nulliparous women or women who are not in monogamous relationships. Part of the confusion is related to the legacy of the Dalkon shield, an IUD marketed in the 1970s. It had a polyfilament string that allowed pathogens to enter the uterine cavity, resulting in an increased risk of PID.

The IUDs available today have a monofilament string, and numerous studies have found no increased risk of PID after the post-insertion period. There is, however, a small risk of PID following insertion (approximately 1/1000). Risk factors include cervicitis, BV, and contamination at the time of insertion. Some of this risk may be mitigated by STI screening prior to insertion in women at risk for cervicitis. IUDs may be used in women with low to intermediate STI risk, but for women at "very high" risk, the CDC designates IUDs as category 3, indicating that the method is not recommended unless no other appropriate alternative exists.

Based on a review of the data regarding IUD use in nulliparous women, the CDC designates IUDs as category 2, indicating that the method may be used although follow-up may be required.

Finally, physician training may be a barrier, particularly for implants, as physicians must be certified to insert and remove them. Training sessions for implants are provided by Merck, the manufacturer, and can be identified on the websites www.implanon-usa.com and www.nexplanon-usa.com.

LARC methods are an excellent option for many women, and are underutilized. If we can all work to break down barriers to LARC use, it could be of great benefit to our patients.

1 Winner, B., Peipert, J., Zhao, Q., Buckel, C., Madden, T., Allsworth, J., & Secura, G. (2012). Effectiveness of long-acting reversible contraception. N Engl J Med, May 24 (21); 366:1998-2007.

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President's Article

Education

David Byck, MD
President, GOGS
Savannah, Georgia

Despite the fact the fallout from HB 954 continues, we are moving on with other important matters that affect Georgia OBGyns. One mission of our Society is to provide innovative and up-to-date education for Georgia physicians and patients. This, indeed, is near and dear to me as a career educator.

Continuing education in obstetrics and gynecology has taken many different roads. In addition to meetings, there are hospital sponsored lectures, on-line seminars, and, let's not forget, the maintenance of certification articles and tests (just to name a few). There are few opportunities, however, for us to get together and have an interactive experience with the leaders in our field who are exploring new techniques and patient care. We have one such opportunity in two short months: Our Annual Meeting!

This year we have a superb faculty with a very diverse set of topics that will be presented for information and discussion. We will even have some time to discuss the implications of HB 954 on our practices. At the same time, we will be able to reunite with our friends and meet new colleagues from around the state in the beautiful environment of The Cloister on Sea Island.

If you are one of our frequent attendees, we welcome you back. If you have never been to an Annual Meeting or have not in many years, please join us. The rooms at The Cloister are filling up fast; but even if they are full, we have alternative accommodations in the area. I believe you will find this to be a most enjoyable way to help with your lifelong learning.

I look forward to seeing you there!

HB 954 Needs Legal Interpretation

Bill Has Implications on Obstetric Care

Ruth Cline, MD
Editor
Athens, Georgia

The legislative session is now over and HB 954 is water under the bridge. We must move on because our patients depend on us to provide their care. The Georgia OBGyn Society serves many roles, as were defined at our strategic planning session in March, 2011. One of the Society's major initiatives is to educate OB-Gyn physicians in the state. HB 954, which goes in to effect on Jan. 1, 2013, is a fetal pain bill, but it has implications on the delivery of routine obstetric care. Legal interpretation is needed and may be forthcoming as actual cases go through the legal system.

The medical implications of the law are murky, but it is possible that the law requires obstetricians to aggressively institute all known medical interventions for any fetus 22 weeks or older. A few clinical examples where current care for the practice of obstetrics would differ from what the law requires are:

1. Your patient is admitted at 21-3/7 weeks with PPROM. The patient is given the option of expectant management at the time of her presentation to the labor ward, which she strongly desires. She is monitored and, with no ensuing labor, 22 weeks arrives. At 22 weeks, the new law would then mandate that aggressive medical care be put in place to result in the delivery of a live newborn. In OB speak, this would require fetal monitoring and, if a non-reassuring fetal heart tracing is noted, a C-section (or hysterotomy), would be required.
2. In a different scenario, the patient at 22 weeks with PPROM, PTL in a non- vertex position will need to be delivered by C-section, as non-vertex vaginal delivery is not consistent with optimal outcomes for the 22 + week fetus.
3. Lastly, the patient who is thought to have a pregnancy of 22 weeks or older and presents with preterm labor (or possibly an incompetent cervix) will require fetal monitoring and, if non-reassuring, a C-section (hysterotomy).

These three scenarios will produce a live birth, but, unfortunately, the newborn will need extensive medical intervention and will often die in the delivery (operating) room.

This change in practice patterns is my interpretation of this law. However, it is most important that you go to your hospital and let your legal counsel interpret how you must practice to comply with this law. This action is most critical because violation of this law is a criminal offense.

You should contact your medical malpractice carrier to determine if they will cover the cost of defending this type of criminal case. If they do not, attorney fees and court costs will be your personal financial responsibility. Therefore, it is critical your community make this legal interpretation that will apply to your practice situations. If not, expensive defense fees, as well as potential jail time, may have an irreversible effect on your ability to practice medicine in the future.

Antibiotic Resistance in Gonorrhea

Kevin Ault, MD; Carlos Del Rio, MD; and Rachel Shuylman, MD

According to the Center for Disease Control, Georgia, with an infection rate of 161.3 per 100,000 population and 15,852 cases in 2010, ranks seventh amongst the States for gonorrhea infections[1]. Fulton County's gonococcal infection rate is even higher, with 297 cases per 100,000 population in 2008. The data and the high HIV prevalence in Fulton County suggest that it is a high-risk community for sexually transmitted infections, including gonorrhea[2].

Over the years, the treatment of gonorrhea infections has been complicated by antibiotic resistance, starting in 1940 when sulfanilamide resistance was first reported. In 1986, to monitor antibiotic resistance trends in gonorrhea, the CDC established the Gonococcal Isolate Surveillance Project (GISP). This surveillance program has been instrumental in monitoring emerging trends in gonorrheal infections, especially those related to antimicrobial susceptibilities. This has been particularly relevant in recent years as most cases of gonorrhea are now diagnosed by non-culture methods, and thus antibiotic susceptibility results are not available to the clinician.

GISP collects gonococcal isolates from the first 25 men who present to STD clinics with urethral gonorrhea and determines those isolates' susceptibilities to a panel of antibiotics. Up to 30 sites participate across the Unites States, and Atlanta (specifically the Fulton County STD Clinic) is one of the 15 sites that has participated annually since 1987. When GISP detects greater than a 5% rate of resistance based on elevated minimum inhibitory concentration (MIC) levels for antibiotics of interest, the treatment recommendations are changed[3].

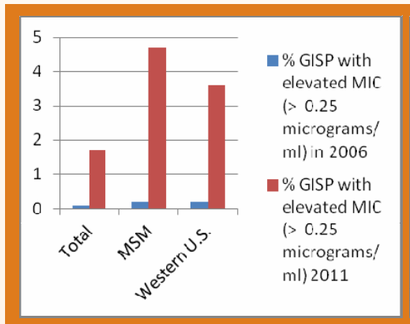


Figure 1. Cefixime Resistance

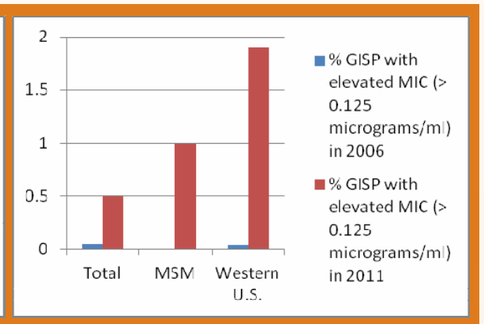
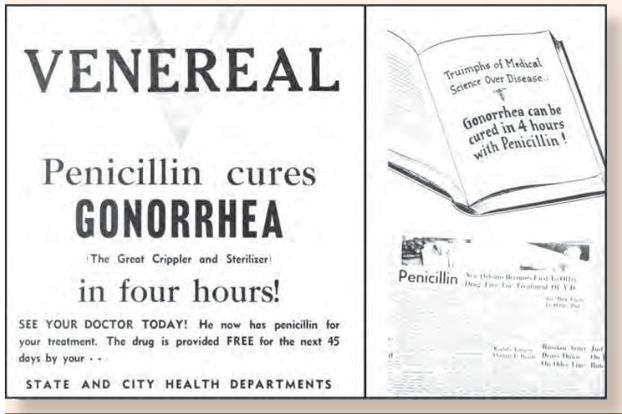


Figure 2. Decreased Ceftriaxone Susceptibility

The treatment of gonorrhea has evolved over time from the simple "four hour cure" with penicillin that was boasted on posters like the one shown here as the treatment of choice for gonorrhea during the WWII era. Penicillin and tetracycline resistance emerged in the 1980s, and flouroquinolones followed suit most recently in 2007[4].



Currently, third generation cephalosporins are the only antibiotics recommended for the treatment of gonorrhea, but we may need to be looking for new options. Cephalosporin resistance is conferred by chromosomal gene mutations. Susceptibility to cefixime and ceftriaxone requires a MIC of ≤ 0.25 micrograms/ml. An increasing percentage of gonococcal isolates with cefixime resistance and decreased ceftriaxone susceptibility has been demonstrated over the past 5 years (Figures 1 and 2).

The higher MIC values have been noted mostly in isolates obtained from men who have sex with men (MSM) and in the western U.S. However, this geographic and demographic trend is concerning because it mimics what was observed during the emergence of fluoroquinolone-resistant gonorrhea. Currently, few GISP isolates from Atlanta have an elevated MIC for cefixime or ceftriaxone, but if the previous pattern of antibiotic resistance emergence is an indicator, it will only be a matter of time[4].

The current CDC guidelines for treatment of gonorrhea are an intramuscular dose of ceftriaxone and oral azithromycin (Figure 3). Oral cefixime should be limited to use only when ceftriaxone is not an option. Infected patients' sexual partners from the previous two months should be treated as well. The only treatment option currently recommended for cephalosporin-allergic patients is 2 grams azithromycin orally. However, 0.5% of GISP isolates showed reduced susceptibility (MIC ≥ 2 micrograms/ml) to azithromycin in 2010. All patients should receive risk-reduction counseling, condoms, and HIV testing with repeat testing if negative 3-6 months later. Patients should be tested for gonorrhea reinfection in three months, and those who are high-risk can be tested for cure one week following treatment. Patients with persistent or recurrent infections should have culture-based gonorrhea testing with antibiotic sensitivities performed as well. Currently this is not readily available in most clinical laboratories, and thus the State Health Department should be notified of all cases of suspected treatment failure so that antibiotic susceptibility testing of the isolate can be performed[4].

Dr. Kevin Ault is Associate Professor in Gynecology and Obstetrics and Global Health at Emory University. Dr. Carlos Del Rio is Professor of Medicine and Global Health and Director of the Atlanta GISP Laboratory. Dr. Rachel W. Shulman, is an Incoming Intern in Obstetrics and Gynecology Residency Program at Emory University.

1 Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance*, 2010. Atlanta, GA: U.S. Department of Health and Human Services; 2011.
2 Dionne-Odom, Jodie, et al. "Antimicrobial Resistant Gonorrhea in Atlanta: 1988-2006." *Sexually Transmitted Diseases* 2011; 38 (8), 780-782.
3 Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2007 *Supplement, Gonococcal Isolate Surveillance Project (GISP) Annual Report 2007*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, March 2009.
4 Bolan, G.A., Sparling, P.F, & Wasserheit, J.N. "The Emerging Threat of Untreatable Gonococcal Infection." *N Engl J Med* 2012; 366:485-487.

Recommended Regimens

Ceftriaxone 250 mg IM in a single dose

OR, IF NOT AN OPTION

Cefixime 400 mg orally in a single dose

OR

Single-dose injectable **cephalosporin** regimens

PLUS

Azithromycin 1g orally in a single dose

OR

Doxycycline 100mg orally twice a day for 7 days

Figure 3. CDC Uncomplicated Gonococcal Treatment Guidelines

Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, MMWR 2010; 59(No. RR-12);52

Georgia OBGyn Society Supports World Breastfeeding Week, August 1-7, 2012

The theme set by the World Alliance for Breastfeeding Action (WABA) is *Understanding the Past - Planning the Future: Celebrating 10 years of WHO/UNICEF's Global Strategy for Infant and Young Child Feeding*. To support World Breastfeeding week and a global strategy to protect, promote, and support breastfeeding, the International Lactation Consultant's Association (ILCA) is offering promotional kits and materials. Their materials' slogan is *The Road to Lifelong Health Begins with Breastfeeding*. For additional information and promotional materials, visit WABA's website, http://worldbreastfeedingweek.org/index.shtml or ILCA's website, http://www.ilca.org/i4a/pages/index.cfm?pageid=3306

Georgia Resources for Breastfeeding:

Healthy Mother, Healthy Babies Coalition of Georgia: http://www.hmhbga.org/
La Leche League of Georgia: https://lllofga.org/
Southeast Lactation Consultants Association: http://www.selca.info/

Highlights from the 2012 Golf Tournament

The Society had a gorgeous day to host the 108 golfers who turned out for the Annual Golf Tournament held at Bear's Best in Suwanee on May 16th. A light lunch preceded the tournament with Dr. Michael Lindsay presenting a short talk on HIV. All teams then lined up for the shotgun start and the tournament was underway. After all teams finished, awards were presented in the club house while everyone enjoyed refreshments. During the tournament, String Hole contributions raised $450 for the Georgia Postpartum Support Network. The Society gives a special thanks to all who made this year's tournament such a wonderful success!

Dr. Dawn Mandeville

Golfers socialized while waiting for the tournament to begin.

Skin Edge and Dr. Andrew Toledo

Dr. Dale Bearman and Dr. Richard Zane

Dr. Bill Alexander, David McNichols, Dr. Phillip Hadley, and Dr. Al Scott

Dr. Jeff Korotkin and Dr. Dale Bearman

Dr. Steve Warnoker, Dr. Mike Scott, Dr. John Moore, and Dr. Tom Sharon

The 2012 Golf Tournament began right after lunch with a shotgun start.

Dr. Cynthia Mercer and Pat Cota

The final results were posted on the tournament scoreboard.

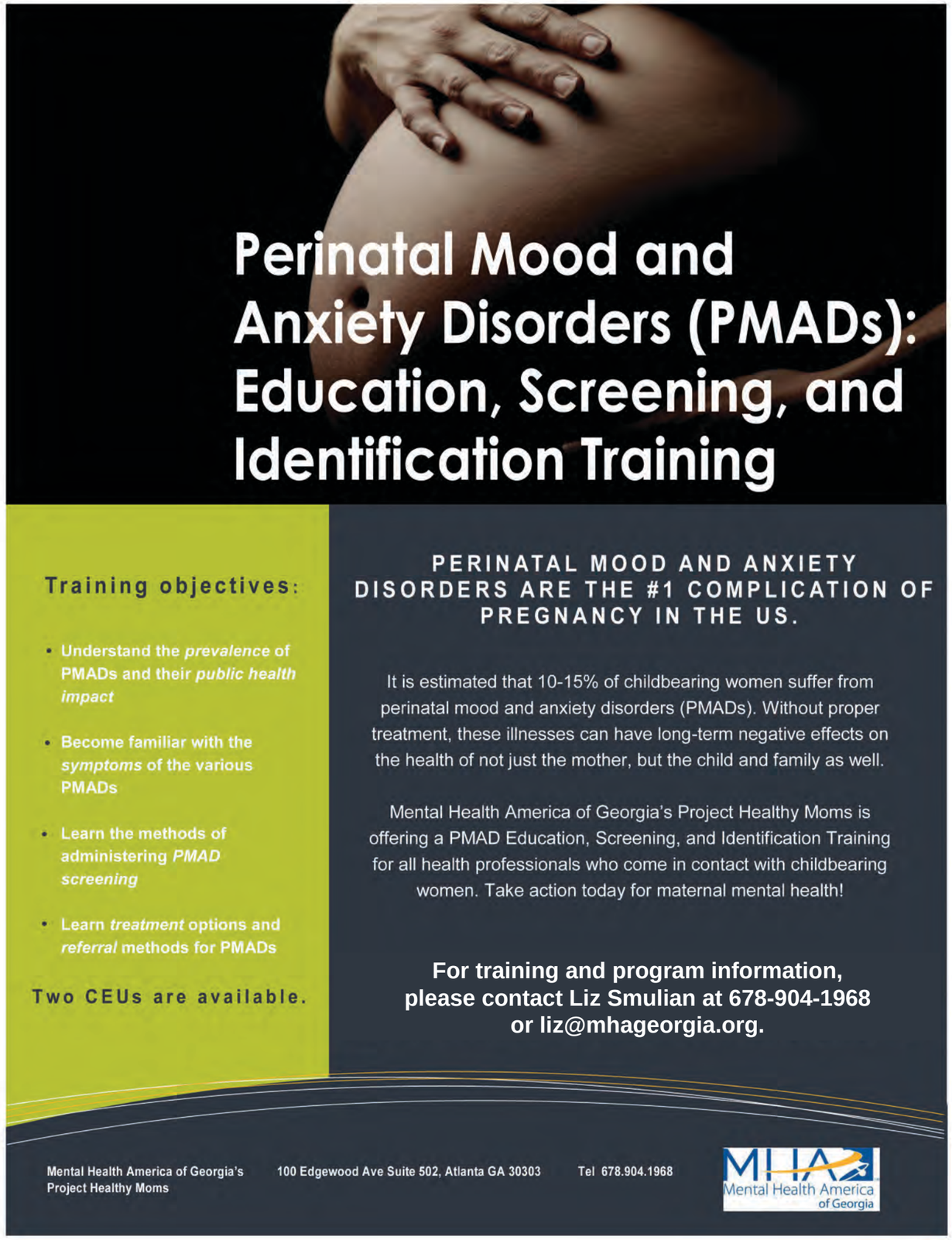
Dr. Jan Johnston and Dr. Mack McFarling

Golfers enjoyed hors d'oeuvres and beverages in the Bears Best club house after the tournament.

Dr. Andy Wilkerson and Dr. Roger Martin

Charlie Grant announced the winners and presented prizes after the tournament.

Dr. Leroy Moyer, Dr. Joel Engel and Dr. David Jacobson



CenteringPregnancy® Program Improves Birth Outcomes in Rural Areas

Caroline Maschke, *Albany GA*

Women due to deliver at approximately the same time meet with their healthcare provider, have refreshments, and share thoughts, concerns and suggestions with other expectant moms.

Southwest Health District is the only Public Health provider in Georgia to offer a group model of prenatal care, and one of only two in the state offering a Centering Healthcare Institute-approved program. Southwest Health District and Dr. Jacqueline Grant initiated CenteringPregnancy® through a March of Dimes grant because the area's birth outcomes compare unfavorably to the rest of the state.

Major factors behind the poor birth outcomes include an African-American population of 41% in a predominantly rural district, racial disparities in birth outcomes, and lack of health care access. Further, a population of Hispanic farmworkers with limited access to care is concentrated in the District's southern counties.

CenteringPregnancy®, with its dynamic atmosphere of empowerment and learning, has been shown to reduce premature births, result in higher birthweight babies and increase breastfeeding. The program appeared to be a good fit for and offer substantial benefits to both populations.

Dr. Jacqueline Grant provides pregnancy information at the Dougherty County CenteringPregnancy meeting.

To eliminate the barriers to prenatal care faced by these populations, Southwest Health District launched its first CenteringPregnancy® site at the Dougherty County Health Department in 2009, catering primarily to African Americans. It opened its second site at the Ellenton Farmworker Clinic in 2011.

Women who participate in the program are admitted prior to Medicaid CMO enrollment. As a result in Dougherty County, the majority of the patients begin their care in the first trimester. The patients in Ellenton are not Medicaid-eligible, and the program eliminates much of the financial barrier for early access to prenatal care. The patients only pay for their lab-work and ultrasounds, which have been negotiated to a third of the cost. Patients are transferred to private providers at 36 weeks.

During the CenteringPregnancy® sessions, a group of eight to 10 women due to deliver at approximately the same time meet one-on-one with their healthcare provider, have refreshments, and circle-up to share thoughts, discuss concerns and suggest solutions within the group.

Activities and circle time are part of the CenteringPregnancy® program.

Women who participated in the program have a high satisfaction rate about their care as well as healthy and happy babies. They report feeling more confident about caring for themselves and their infants.

Carolyn Maschke is Risk Communicator/Public Information Officer for the Southwest Georgia Health District 8, Unit 2.

Tobacco Cessation Efforts Target New Mothers

New Moms at Elevated Risk to Resume Smoking

The Georgia Department of Public Health (DPH), Health Promotion and Disease Prevention Programs recently expanded their free specialized tobacco cessation counseling services in an effort to help postpartum women quit tobacco products.

In Georgia, approximately 600,000 women smoke cigarettes. Among women who quit smoking during pregnancy, postpartum relapse rates for tobacco use remain high. According to Georgia Pregnancy Risk Assessment Monitoring System (PRAMS) data, approximately 8 percent or 11,000 pregnant women report they smoked cigarettes during the last three months of their pregnancy. Evidence shows more than 1/2 of pregnant women who quit smoking resume smoking within six months of giving birth.

More specifically, it is estimated more than $4.5 billion per year, in direct medical expenditures, can be attributed to parental smoking to care for smoking-related problems of newborns, infants and young children, as well as to treat pregnancy and birth complications. These estimates do not include the enormous costs associated with the physical, developmental, and behavioral problems of newborns, infants, and children related to smoke exposure over the years.

Parental or other household smoking following birth may further increase the chances that children will suffer from smoke-related coughs and wheezing, asthma, bronchitis, lower respiratory tract infections, sudden infant death syndrome (SIDS), eye and ear problems, as well as injury or death from cigarette-caused fires.

DPH is encouraging post-partum mothers to quit tobacco with the assistance of free tobacco cessation counseling and web-based services which are administered through the Georgia Tobacco Quit Line (GTQL) to adults and teens 13 to 17. The expansion of the GTQL specialty counseling services is designed to increase awareness about the harmful effects of tobacco use and secondhand smoke, promote the benefits of cessation, and prevent relapse. Callers connect with professionals who develop an individualized plan customized to address tobacco cessation, withdrawal symptoms and relapse prevention. Callers receive a free "Quit" kit and self-support materials. Referring healthcare professionals may also elect to receive customized patient/client progress or feedback reports.

The GTQL is operated by a national tobacco cessation service vendor under a contract with the Georgia Department of Public Health (GPH) through the Georgia Tobacco Use Prevention Program (GTUPP). The GTQL provides tobacco counseling services in accordance with current United States Public Health Services (PHS) Clinical Practices Guidelines for Treating Tobacco Use and Dependence. The Georgia Tobacco Quit Line (GTQL) numbers are 1-877-270-STOP (7867) English; 1-877-2NO-FUME; (1-877-266-3863)-Spanish; and for hearing impaired (TTY services) 1-877-777-6534.

To learn more about adult smoking and the latest findings in the US, visit http://www.cdc.gov/VitalSigns/AdultSmoking/?s_cid=vitalsigns-086-bb and http://www.cdc.gov/vitalsigns/SocialMedia.html#AdultSmoking or contact the Department of Public Health, Dwana Calhoun, MS, CHES, at dwcalhoun@dhr.state.ga.us.

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