Editorial

Adolescents and Contraception: The Updated US Medical Eligibility Criteria for Contraceptive Use

The *Journal of Pediatric and Adolescent Gynecology* marks and celebrates the release of the latest update to the US Centers for Disease Control and Prevention (CDC) US Medical Eligibility Criteria for Contraceptive Use, often referred to as the US MEC, and its companion, the US Selected Practice Recommendations for Contraceptive Use, the US SPR. The North American Society for Pediatric and Adolescent Gynecology has endorsed these documents. This issue of the *Journal of Pediatric and Adolescent Gynecology* includes an excellent, timely, and thorough mini-review by Drs Andrea Hoopes, Katharine Simmons, Emily Godfrey, and Gina Sucato,[1] which highlights the recommendations contained in these documents as they pertain to our adolescent patients. The lovely review highlights the guidance from the US MEC and US SPR regarding specific clinical issues in our care of adolescents, especially those with medical conditions who most particularly need effective contraception.

As noted on the CDC Web site (http://www.cdc.gov), the US MEC, which were last published in 2010, is intended to assist clinicians when counseling about contraceptive method choices. The document provides guidance about the safety of using various categories of contraceptives for girls and women with a variety of specific medical conditions and characteristics. The US MEC are based on the World Health Organization (WHO) MEC, initially published in 1996, and include adaptations of selected WHO recommendations, as well as a focus on contraceptive methods that are available in the United States. The most recent update involved extensive systematic reviews of the updated world literature and evidence about contraceptive safety (these reviews themselves have been subject to peer review and have been submitted or published in peer-reviewed journals). In a convened meeting, the CDC sought input from obstetricians/gynecologists, pediatricians, family physicians, nurse-midwives, nurse practitioners, epidemiologists, and others with expertise in specific medical conditions. I was privileged to be among those who provided input to the CDC on this latest update. The US MEC focuses on topics that are pertinent to practitioners in the United States, with a recognition of the generally high level of medical resources that are available in this country. The CDC also gathered information to inform a research agenda on topics that merit further investigation.

For those who are not familiar with the US MEC, the document includes tables with recommendations for the use of classes of contraceptive methods (combined hormonal methods, progestin-only methods, emergency contraceptive pills, intrauterine contraception, copper intrauterine devices for emergency contraception, etc) in women with specific medical conditions or characteristics (such as age younger than 18 years). The safety of contraceptive methods in a given situation (medical condition or patient characteristic) was classified into 1 of 4 categories. The categories are defined in Table 1.

Of note, with regard to age, almost all classes of contraceptive methods for healthy adolescents are categorized as category 1; depot medroxyprogesterone acetate is a category 2 for individuals younger than 18 years, because of issues related to bone density, and intrauterine devices are also a category 2, because of a possible increased risk of expulsion in nulliparous women, as well as risks for sexually transmitted infections in adolescents.

The MEC lists conditions that are associated with an increased risk for adverse health events as a result of unintended pregnancy. For women with these conditions that might make unintended pregnancy an unacceptable health risk, the document concludes that long-acting, highly effective contraceptive methods might be the best choice, and that the sole use of barrier and behavior-based methods might not be the most appropriate choice because of their relatively higher typical-use failure rates. This advice is important to consider as we work with colleagues and subspecialists who might have outdated information about the potential health risks of long-acting reversible contraception methods. Of course we are all aware that most adolescent pregnancies are unintended. Being able to refer to and cite the updated US MEC and SPR might help us to provide effective contraception to our patients with specific high-risk conditions for which additional health risks would result if an unintended pregnancy were to occur.

The companion document to the US MEC is the US SPR, published in 2013, which addresses how to use contraceptive methods. It is my observation that although most clinicians who practice adolescent gynecology are at least somewhat familiar with the US MEC, fewer are aware of the guidance provided by the US SPR, which provides guidance on the management of specific barriers to successful contraceptive use (such as the evidence on how to manage breakthrough bleeding with specific hormonal methods). I find that the residents that I work with in obstetrics/gynecology and pediatrics are usually familiar with the MEC, but are less likely to be familiar with the SPR. I would encourage clinicians to become familiar with the US MEC as well as the US SPR, because they help us to provide the latest evidence-based care to our patients. I consult the CDC Web site or the CDC Contraception App multiple times a week, because they summarize practical information and evidence.

1083-3188/$ - see front matter
http://dx.doi.org/10.1016/j.jpag.2017.01.001

Table 1
Categories for Classifying Hormonal Contraceptives and IUDs

Category	Definition
1	A condition for which no restrictions exist
2	A condition for which the advantages of using the method generally outweigh the theoretical or proven risks
3	A condition for which the theoretical or proven risks usually outweigh the advantages of using the method
4	A condition that represents an unacceptable health risk if the method is used

I suspect that although most North American Society for Pediatric and Adolescent Gynecology members and clinicians who care for adolescents are familiar with the US or the WHO MEC, not all are aware of the ease of use of the CDC App, and not all are aware of the recently released updated MEC. I challenge us all to shamelessly proselytize and teach our colleagues in other specialties, as well as our colleagues in pediatrics or gynecology who do not routinely care for adolescents, about the newly updated US MEC and US SPR as they apply to adolescents. The mini-review by Dr Hoopes and colleagues in this issue of the *Journal of Pediatric and Adolescent Gynecology* is a great place to get information on these updates about adolescents and contraception.

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http://dx.doi.org/10.1016/j.jpag.2017.01.001

Reference

1. Hoopes AJ, Simmons KB, Godfrey EM, Sucato G. J Pediatr Adolesc Gynecol 2017; 30(2):149-55.