The Telephone Call
Facilitator's Guide

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Topic: Oral Contraceptive Scenarios

Abstract:
Six vignettes simulate telephone calls from teens concerned about problems encountered with oral contraceptive (OC) use. This exercise is intended to follow "The Hidden Agenda" case on contraceptive counseling.

Goal:
To provide learners with an understanding of how to manage common concerns of patients using oral contraception.

Objectives:
By the end of this session, learners will be able to:
1. Answer questions from teens using oral contraception.
2. Manage common problems such as breakthrough bleeding and missed pills in teen oral contraceptive users.

Prerequisite Cases:
"But All My Friends Do It" (Middle Adolescent Health Screening)
"The Hidden Agenda" (Contraception)

Related Cases:
"Manuel's Disclosure" (HIV and the Adolescent)
"Too Many Periods" (Dysfunctional Uterine Bleeding)
"The Burning Issue" (Sexually Transmitted Diseases)
"Decisions to be Made" (Teen Pregnancy)
"Amy Goes to College" (Older Adolescent Health Screening)

Themes:
Adolescent Health

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Key Words:
Oral contraceptives, birth control pills, estrogen, progestin, reproductive history, sex counseling, family planning, adolescent health services, pregnancy, contraception

Bright Futures Core Concepts:
While all of the Core Concepts are included in each case, this particular case can be used to highlight prevention/health promotion.

Materials Provided:
- Facilitator's Guide
- 6 vignettes: Simulated telephone calls from teens concerned about problems encountered with oral contraceptive (OC) use.
- Handout #1: Oral Contraceptives Available in the United States
- Bibliography

Facilitator Preparation:
Facilitators should thoroughly review this guide and the other materials provided.

At the end of the guide we have included a section entitled, "**Independent Learning/Prevention Exercises**," that will further stimulate group and individual education on this topic. (Please note that this is the same suggestion list as in the prerequisite case on Contraception, *"The Hidden Agenda."*)

Suggested Format of a One Hour Session:
We anticipate that case facilitators will modify implementation of the case session to best fit their educational setting and learners. For detailed recommendations on case facilitation, please see the chapter entitled, "A Brief Guide to Facilitating Case Discussion," found in *The Case Teaching Method; and Growth in Children and Adolescents* (book 1 of this series).

Open the Discussion: Let the learners know that they are on call for the Adolescent Practice. They should have oral contraceptive (OC) instructions, various OC samples in front of them, and a list of available OCs. They should have already completed "The Hidden Agenda" case. Six short patient vignettes are included with these materials. Each can be read and then discussed among all learners, or facilitators may wish to ask two group members to "role play" each vignette, with one learner taking the part of the health care provider and the other the part of the patient. The "patient" is given the vignette and asked to read over silently before playing the role. Other learners can help with asking the patient questions if the "doctor" appears stumped. Each vignette should take 7-10 minutes.

Vignette #1: Breakthrough Bleeding (BTB)
Tanya is a 16 year old who calls the clinic on Monday morning at 8 AM; she is dressing to go to school when she experiences cramping, abdominal pain and vaginal bleeding. Tanya has completed two cycles of oral contraceptives and is now on day 11 of her new package. She is in a sexual relationship and her partner is an inconsistent user of condoms. Tanya insists she has taken her pills daily within 30 minutes of her designated time. She did not have breakthrough bleeding with her first two cycles. She has been stressed lately due to school demands.

Breakthrough Bleeding (BTB):

Breakthrough bleeding is common in the first three months of oral contraceptive use and usually resolves without therapy. Since BTB is a major source of discontinuance, it is important to address this potential problem at the time of initiating OCs. Teens should be reassured that it can usually be ignored and will improve. However, in this case Tanya had no BTB during her first 2 cycles and now has abdominal pain, cramps, and bleeding, suggesting a pathologic etiology. In reviewing Tanya's history, the health care provider should elicit information about the common causes of irregular bleeding and cramps: missed pills, STDs (Chlamydia trachomatis or gonorrhea), or pregnancy. Concurrent use of medications (e.g. anti-convulsants, rifampin) can cause BTB by increasing the metabolism of OCs.

The patient may initially state that she has not missed a pill and give a different answer to the question: *"It's hard to remember to take pills all the time, how many do you think you have missed?" "What do you find is particularly difficult about pill-taking?"* Since Tanya denies missing pills and has a history of unprotected intercourse, a pregnancy test, a screen for STDs (Chlamydia and gonorrhea), and an examination to exclude pelvic inflammatory disease (PID) are indicated.

There are several choices when BTB is not caused by missed pills or pathologic conditions and is persistent over several months. The pill formulation can be changed to increase the progestin dose, such as change from a pill with 0.4 or 0.5 mg of norethindrone (e.g. Ovcon-35 or Modicon)* to a pill with 1.0 mg of norethindrone (e.g. OrthoNovum 1/35); a pill with 1 mg of norethindrone and 20 ug ethinyl estradiol (Loestrin 1/20) to a pill with 0.1 mg levonorgestrel and 20 ug of ethinyl estradiol (Alesse); or pills with norethindrone (e.g. OrthoNovum 1/35 or OrthoNovum 7/7/7) to pills with levonorgestrel or norgestimate (Triphasil, LoOvral, Nordette, OrthoCyclen)*. The estrogen dose can also be increased from 20 ug ethinyl estradiol to 30 or 35 ug ethinyl estradiol. It is rare to need an OC with 50 ug of ethinyl estradiol. Additionally, the patient can double up pills for 2-3 days (the extra pills should be drawn from an extra package) until BTB ceases and then return to 1 daily. Many clinicians prefer to prescribe ethinyl estradiol 20ug or conjugated estrogens 0.625 mg each day, 12 hours after the OC, for 7 days or though one cycle.

(*The pill names given do not imply an endorsement of any particular brand names but are used only as illustrations for patient management.)

Vignette #2: Nausea
Joan is a 17 year old who calls her primary care provider on Wednesday and says that she has been having nausea since she started the pill two weeks ago. She usually takes her pill in the early morning and rarely eats anything before noon or one o'clock.

Nausea

Nausea is common in the first week or two of initiating OCs and usually decreases after the first month. It is an estrogenic side effect and is often lessened by having the patient change the time of day her pill is taken. She can take her OC at bedtime with a snack or after dinner (6-7 PM). She should be encouraged to eat a small meal in the morning. If this is not effective and the symptoms are bothersome or persistent for the patient, a pill with less estrogen can be prescribed (35 ug to 30 ug or to 20 ug). Alternatively, a pill with a stepwise increase in estrogen content or a progestin only pill can be used. Pregnancy should always be considered in any adolescent with persistent nausea. Since nausea is a distressing side effect and can compromise compliance, it is very important that it be addressed promptly.

Vignette #3: Oligomenorrhea / Amenorrhea

Lisa is an 18 year old who calls her primary care provider on Wednesday afternoon upset because she missed her last period. Despite the fact that Lisa has been on the pill for 11 months and has not had intercourse in 8 months, she is worried about pregnancy. When questioned, she does admit that her period has greatly diminished since being on oral contraceptives compared to what she experienced before. This reduction in flow has been a steady progression. Her previous period lasted barely one day, and with this cycle there was no visible flow. She has just started another package of pills.

Oligomenorrhea / Amenorrhea

OCs characteristically produce significantly lighter periods (which results in less iron deficiency anemia in OC users). Preparing a patient for this reduction in flow diminishes her concern about the oligomenorrhea. For some OC users, the oligomenorrhea is followed by amenorrhea as it did in Lisa's case. Regardless of the patient's verbal history of her coital experience, it is prudent to obtain a sensitive urine pregnancy test and explain to the patient that this is a routine procedure. Lisa should be reassured that light menses or skipped menses are common and can usually be ignored. Menses usually resume on their own. When there is ongoing amenorrhea, the patient should be reassured that there are *no* medical problems associated with amenorrhea, provided she is not pregnant. To assure she is not pregnant, she can obtain a sensitive pregnancy test every 2 months that she skips her menses. She can also check her basal body temperature during the placebo week (the temperature should be less than 98 degrees if the patient is neither sick nor pregnant). If the amenorrhea is an ongoing source of concern to the patient, she can be offered a change of OC to one that is less progestin-dominant (e.g. a triphasic pill or a pill with 0.4-0.5 norethindrone). There is no relationship between amenorrhea on the OC and post-pill amenorrhea, which is usually associated with either weight loss or polycystic ovary syndrome.

Vignette #4: Weight Gain

Latoya is a 17 year old girl with polycystic ovary syndrome who calls the Thursday evening before Memorial day weekend. She has just returned from the mall and summer clothes shopping. She is very upset that she could not wear her usual size. She is sure that she has gained 10 pounds in the past 4 months since starting the oral contraceptive pill in order to treat her acne and hirsutism. Latoya wants her problems to be addressed tonight. How can she return to school in four days looking like this?

Weight Gain

The first step in Latoya's management is to determine her actual weight. Many teens perceive that they have gained weight when in fact their weight is unchanged. She can be seen the next day in the office to check a weight on the same scale used previously. When she initiated the

OC, she should have been questioned about previous problems with weight loss and gain and a history of dieting. Adolescents prone to weight gain should be counseled to avoid fast foods and increase exercise and decrease TV time to lessen the possibility of weight gain. With her underlying diagnosis of polycystic ovary syndrome, she may also be at increased risk of gaining weight easily.

Studies in more than 200 adolescents have shown no mean weight gain; some teens lose weight, some gain and most stay the same. Despite Latoya's demand for instant correction of her problems, there are no quick solutions if she has truly gained weight. The most important options are nutritional education focusing on decreasing calories consumed and types of food eaten (low fat) and an increase in exercise on a daily basis. If compliance with the pill is likely to be a problem or the patient's appetite seems to have increased, the patient can be offered an OC lower in both progestin and estrogen.

Vignette #5: Missed Pills

Rebecca is an 18 year old who calls from school. She is a freshman in college living in a dorm with two roommates. When she returned from getting her first tattoo, a butterfly on her right shoulder, she realized that she had missed taking two pills. Rebecca admitted she had also taken several pills late in her last cycle and even missed one completely.

Missed Pills

Missed pills and late pills are problems for many OC users. Under the best of circumstances, it is difficult for most patients to comply by taking their medication exactly as prescribed. The often frenetic life of a college student is not conducive to pill compliance. Teens frequently underreport the degree of compliance to the health care provider. When counseling Rebecca, the provider should keep the instructions simple. Connect the pill taking with a daily behavior. Because of her shared living situation, a private place such as a drawer she opens daily may be an adequate prompt. For the days she does forget, teach her the "doubling up" technique i.e. take your forgotten pill as soon as you remember and the pill for that day at the regular time.

The instructions for dealing with missed pills should be on an instruction sheet and are found with the patient handout that accompanies the oral contraceptive pills:

- If the patient misses one pill, takes as soon as she remembers. She takes the regular pill for that day at the normal time.
- If patient misses two pills in first 2 weeks, take 2 pills a day for 2 days and then 1 pill a day until pack is finished. Use a back-up method of contraception for 7 days
- If patient misses two pills in a row during the third week OR misses three pills or more in a row any time, then:
    - Sunday starter: Keep taking a pill every day until Sunday. On Sunday throw away the unused portion and start a new pack. Use a back-up method of contraception for at least 7 days.
    - Non-Sunday starter: Throw away rest of current pack and start a new pack the same day. Use a back-up method of contraception for at least 7 days.
- Patients should also strongly consider using emergency contraception if they have missed 2 or more pills and have had unprotected intercourse within 72 hours.

Patients living away from home benefit from having their health care provider accessible to them for continuity of care; however, patients should also learn to access their college health center.

Vignette #6: Depression, Moodiness, and Headache
Rhonda is a 19 year old who calls during her shift break while working at a nursing home. Since leaving school to deliver her daughter, she has been working as a dietary aide. She'll finish her GED in two months and expects to apply to the community college in the neighboring town. Rhonda is concerned about moodiness and depression. She is crying and getting upset over situations that never troubled her before. She has also noticed an increase in frontal pressure headaches, which are relieved by ibuprofen. Rhonda has been on a triphasic pill for the two years since her baby was born. She has been a compliant pill user and is motivated to avoid another pregnancy. She wonders if the pill is contributing to her moodiness and headaches.

Depression, Moodiness, and Headache

Depression, sadness, mood swings, increased emotional response, crying, and anxiety have all been reported by OC users, although studies on whether these effects can be attributed to OC use are conflicting. Life circumstances are the usual causative factors for these emotional problems. However, some pill users have noticed a reduction and even cessation of symptoms when the pill is stopped. Although Rhonda has many stressors in her life, she is also goal orientated and motivated to succeed. Given her level of involvement with her daughter, school, work, and future educational plans, she does not appear to be depressed.

Since Rhonda is in a sexual relationship and does not desire a pregnancy, uninterrupted contraception is essential. She should receive supportive counseling and be encouraged to continue the OC. If compliance is likely to become a problem, she can stop her present pill at the end of the cycle and start a new pill without disturbing the pill sequence. The new OC should be a different formulation from her present pill. This is an opportune time to review other available methods of contraception with Rhonda. She may wish to stop the pill for a month or two, but she then needs to find a reliable alternative method of contraception. Should she continue to have emotional problems despite a pill change, mental health assessment and counseling are advisable.

Headaches are common in normal adolescents (10-30% have a headache once a week). Patients may have new onset or increased headaches while taking OCs. Providers should therefore take a thorough neurological (i.e. headache) history at baseline. An adolescent complaining of new or increased headaches should be evaluated and her blood pressure checked. The history should be reviewed to see if other factors such as stress, caffeine, or a sinus problem are contributing to the headaches. Depending on the severity of the headaches (especially if they are severe migraine headaches), the health care provider may need to change the patient to a lower dose pill and see if headaches are improved. A change to a 20 ug pill can be tried or, occasionally, a trial of progestin only method is indicated.

Distribute the Bibliography. Refer back to group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Independent Learning/Prevention Exercises: Facilitators may wish to assign "Independent Learning/Prevention Exercises" to the group, particularly if time constraints hinder the completion of the case. The following list includes suggestions to explore the available community resources that focus on Contraception which can be integrated during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Find out where patients can receive free or low cost contraceptive services.
2. Practice a "show and tell" with different contraception types/pill packs (how to explain these to a patient and how to promote abstinence and safer sex).
3. Interview a peer educator.
4. Find out what is being taught about sexuality, abstinence, contraception, and HIV protection in the local schools (and check the accuracy of the information).
5. Offer to give a talk or serve as a resource to a high school or community group.

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Handout #1: Oral Contraceptives Available in the U.S. (Many generics are also available)

Drug	Estrogen	(mcg)	Progestin	(mg)
Demulen l/50	ethinyl estradiol	50	ethynodiol diacetate	l.0
Ovral	ethinyl estradiol	50	norgestrel	0.5
Ovcon-50	ethinyl estradiol	50	norethindrone	l.0
Norinyl 1+50, OrthoNovum l/50	mestranol	50	norethindrone	1.0
Norinyl 1+35, OrthoNovum 1/35	ethinyl estradiol	35	norethindrone	1.0
Demulen l/35	ethinyl estradiol	35	ethynodiol diacetate	l.0
Jenest	ethinyl estradiol	35	norethindrone	0.5 x 7 d. 1.0 x 14 d.
Ortho-Novum 7/7/7	ethinyl estradiol	35	norethindrone	0.5 x 7 d. 0.75 x 7 d. 1.0 x 7 d.
TriNorinyl	ethinyl estradiol	35	norethindrone	0.5 x 7d l.0 x 9d 0.5 x 5d
Ortho-Cyclen	ethinyl estradiol	35	norgestimate	0.25
Ortho-TriCyclen	ethinyl estradiol	35	norgestimate	0.180 x 7d 0.215 x 7d 0.250 x 7d
Brevicon, Modicon	ethinyl estradiol	35	norethindrone	0.5
Ovcon-35	ethinyl estradiol	35	norethindrone	0.4
Lo/Ovral	ethinyl estradiol	30	norgestrel	0.3
Loestrin l.5/30	ethinyl estradiol	30	norethindrone acetate	l.5
Nordette	ethinyl estradiol	30	levonorgestrel	0.l5
Desogen, OrthoCept	ethinyl estradiol	30	desogestrel	0.15
Triphasil, TriLevlen, Trivora	estradiol	30 40 30	levonorgestrel	0.050 x 6d 0.075 x 5d 0.125 x 10d
Loestrin l/20	ethinyl estradiol	20	norethindrone acetate	l.0
Estrastep	ethinyl estradiol	20 x 5 d. 30 x 7 d. 35 x 9 d.	norethindrone acetate	l.0
Alesse, Levlite	ethinyl estradiol	20	levonorgestrel	0.10
Mircette	ethinyl estradiol	0 x 2 d. 10 x 5 d. 20 x 21 d.	desogestrel	0.15 x 21 d.
Ovrette			norgestrel	0.075
Nor-Q.D., Micronor			norethindrone	0.35

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Bibliography

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2. Emans SJ, Laufer MR, Goldstein DP. *Pediatric and Adolescent Gynecology,* Fourth edition. Philadelphia: Lippincott, Williams and Wilkins; 1998. p. 611-674
3. Speroff L, Darney P. *A Clinical Guide for Contraception,* Second edition. Baltimore, MD; Williams and Wilkins; 1996.
4. Hatcher RA, Zieman M, Watt AP, et al. *A Pocket Guide to Managing Contraception*. Tiger, Ga: Bridging the Gap Foundation; 1999.

Suggested Reading (Annotated):

Emans SJ, Laufer MR, Goldstein DP. *Pediatric and Adolescent Gynecology,* Fourth edition. Philadelphia: Lippincott, Williams and Wilkins; 1998.
This text provides a chapter on counseling the teen on contraceptive options, the health benefits and risks of the hormonal methods, an overview of barrier methods, and a review of studies on contraceptive compliance in teens.

Educational Resources on the World Wide Web:

Planned Parenthood Federation of America
http://www.plannedparenthood.org and http://www.teenwire.com

American Social Health Association—ASHA's sexual health information web site geared towards teens.
http://www.iwannaknow.org

The Children's Hospital League's Young Women's Resource Center website:
http://www.youngwomenshealth.org/information_sheets.html

Plan B website: http://go2PlanB.com