Attendee Info Field	Response Text	Reply Text
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	Can you speak to CDC guidance (or what can be extrapolated from it) re any unique considerations for transmen and transwomen, both for pregnancy prevention (transmen) and STI prevention (transmen and transwomen, as well as gender diverse people)? How should we move forward in this space with the removal of data and guidance relevant to trans and gender-diverse people under the new administration?	CDC contraception guidelines (US Selected Practice Recommendations for Contraceptive Use) include a recommendation on testosterone use and risk for pregnancy: Counsel that testosterone use might not prevent pregnancy among transgender, gender diverse, and nonbinary persons with a uterus who are using testosterone. Offer contraceptive counseling and services to those who are at risk for and do not desire pregnancy. (https://www.cdc.gov/contraception/hcp/usspr/testosterone-pregnancy-risk.html) CDC also provides information for transgender and gender diverse persons in the Sexually Transmitted Infections Treatment Guidelines: https://www.cdc.gov/std/treatment-guidelines/default.htm CDC contraception guidelines (https://www.cdc.gov/contraception/hcp/contraceptive-guidance/index.html) and CDC STI guidelines are currently available and up to date on the CDC website. Providers may wish to download these resources for use with patients.
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	Can you touch upon the new change regarding DMPA being a category 3 for sickle cell anemia patients? As I resident, I practiced in a hospital with a large sickle cell anemia patient population, and DMPA was often our first line of treatment for those patients given it can decrease rates of vaso-occlusive crises, but with the 2024 recommendations I'm no longer sure how to navigate this. Thank you!	The updated US MEC recommendation for DMPA use among patients with sickle cell disease is MEC 2/3, depending on the severity of the condition and risk for thrombosis. While some evidence suggests that progestin-only contraception (including DMPA) might be beneficial in reducing clinical symptoms (e.g., pain crises), there is updated evidence that 1) persons with sickle cell disease are at higher risk for stroke and venous thrombosis than the general population, and 2) DMPA use is associated with a higher risk for venous thrombosis compared with nonuse. Therefore, the updated US MEC recommendation reflects the concern that DMPA use might further elevate risk for thrombosis among persons with sickle cell disease. However, the MEC 2/3 category provides flexibility depending on an individual patient's risk for thrombosis.
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	How should clinicians remain up to date on best practices in contraceptive care once the current MEC/SPR become out of date (given the current administration's impact on the CDC)?	The current US MEC and US SPR were updated in 2024 and the recommendations and materials on the CDC website are currently up to date. Providers are encouraged to download those materials for easy reference to use with their patients. Because materials were recently updated, they should remain current for some time. In the past, CDC has updated the guidelines about every 5-8 years. However, providers may also want to seek out other sources to remain up to date.
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	If drospirenone only pills (Slynd) shut down cycles without giving estrogen, are you seeing cases of hypo estrogen in patients like we can see with depo? If we are using Mirena/Liletta for emergency contraception, is it still true that they do not start working for contraception for a week like the lower dose IUDs? If we replace a hormonal IUD, does a patient really need back up contraception for a week? What is the latest on the efficacy of Phexxi?	Estradiol levels are not completely suppressed with use of drospirenone-only pills. Plasma estradiol levels remain within the range of the early follicular phase of the menstrual cycle and do not drop below 30 pg/ml with 4 mg drospirenone in a 24/4 dosing regimen; therefore, no negative impact on bone health or hypoestrogenic state is expected. https://www.tandfonline.com/doi/epdf/10.1080/13625187.2020.1743828?needAccess=true https://www.tandfonline.com/doi/epdf/10.1080/13625187.2021.1957094?needAccess=true Mirena/Liletta for EC: Recommendations for use of hormonal IUDs for emergency contraception are not included in US MEC/SPR. LNG-IUD back-up: There is no evidence that the levonorgestrel has any carry-over effect after removal of the LNG-IUD. Therefore, when replacing an LNG-IUD, if it has been > 7 days since menstrual bleeding began, the patient needs to abstain from sexual intercourse or use barrier methods (e.g., condoms) for the next 7 days. Efficacy of Phexxi: Data on efficacy of Phexxi come from the label. The estimated Pearl Index, calculated based on data from the 7-cycle study, was 27.5 (95% CI: 22.4%, 33.5%) (https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/208352s000lbl.pdf). This corresponds to an approximate typical use effectiveness rate of 21 pregnancies for every 100 users during the first 13 cycles of use (https://contraceptivetechnology.org/wp-content/uploads/2023/12/1st-Year-Pregnancies.png).
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	please comment on both bleeding and clotting disorders with regards to COCs - there is varied literature on this matter and I see them as 2 sides to the same issue - concern for me as prescriber of COCs to women with VonWillebrands - as a bleeding event risks DIC and estrogen increases this risk as well.	The US MEC recommendation for COC use among patients with thrombophilia is MEC 4. The updated US MEC recommendation for COC use among patients with history of deep venous thrombosis (DVT) or pulmonary embolism (PE) is stratifed by anticoagulant use: MEC 4 if therapeutic dose, MEC 3 or 4 if prophylatic dose and based on risk for recurrent DVT/PE, or MEC 3 or 4 if no anticoagulant use and based on risk for recurrent DVT/PE. There is no US MEC recommendation for bleeding disorders (e.g., von Willebrand disease). US MEC recommendations refer to contraceptive methods being used for contraceptive purposes. However, patients with bleeding disorders are at risk for gynecologic complications, such as heavy or prolonged bleeding. and use of some hormonal contraceptives may be of benefit in preventing or treating this complication. When a contraceptive method is used as a therapy, rather than solely to prevent pregnancy, the risk/benefit ratio might differ and should be considered on a case-by-case basis.
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	Please provide a brief overview of migraines with aura. Does the aura have to precede the actual HA or can it occur during or after?	While the US MEC/SPR does not provide an overview of migraines with aura, several overviews are available for clinicians, such as: https://www.ncbi.nlm.nih.gov/books/NBK554611/ Definitions and diagnostic criteria for migraines and aura can be found here: https://ihs-headache.org/wp-content/uploads/2025/04/ICHD-3-Cephalalgia-2018-issue-1.pdf
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	So we anticipate there will ever be a contraceptive indication for norethindrone acetate which is currently indicated for menstrual suppression/ abnormal uterine bleeding?	We are not aware of any efforts to change the labeling for norethindrone acetate.
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	updates to Depo recs for SCD patients with dysmenorrhea	The US MEC does not directly address use of DMPA among patients with sickle cell disease and dysmenorrhea. For patients with severe dysmenorrhea, DMPA is MEC 1. While some evidence suggests that progestin-only contraception (including DMPA) might be beneficial in reducing clinical symptoms (e.g., pain crises), there is updated evidence that 1) persons with sickle cell disease are at higher risk for stroke and venous thrombosis than the general population, and 2) DMPA use is associated with a higher risk for venous thrombosis compared with nonuse. Therefore, the updated US MEC recommendation reflects the concern that DMPA use might further elevate risk for thrombosis among persons with sickle cell disease. However, the MEC 2/3 category provides flexibility depending on an individual patient's risk for thrombosis.
CDC Contraception Guidance: U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) and U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)	Will there be change regarding usage of estrogen in patients with migraines with aura? Neurology keeps saying it is ok.	The US MEC recommendations for use of combined hormonal contraceptives (CHCs) among patients with migraine with aura did not change in the 2024 update. Currently, migraine without aura (including menstrual migraine) is MEC 2 for CHCs, and migraine with aura is MEC 4 for CHCs. While more evidence is needed, oral contraceptive use is associated with an increaased risk of stroke in patients with migraine (with and without aura). Evidence also suggests that migraine with aura is associated with a greater risk for stroke than migraine without aura. Accurate diagnosis of migraine and aura is critical, as is shared decision-making among the patient and their health care providers.