WOMEN AND ALCOHOL

HOW MUCH IS TOO MUCH?
Alcohol-related mortality represents the third leading cause of preventable death for women in the US, and women are particularly vulnerable to the physical and psychosocial health risks of at-risk alcohol use. How can we effectively identify at-risk drinking and alcohol dependence in our patients? The College has released Committee Opinion #496, *At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications*, addressing this question and the unique role of our specialty.

How much is too much? Many women may be surprised to learn that their drinking exceeds a safe level. They may associate with others who drink similar amounts and consider their alcohol use “normal.” At-risk alcohol use is defined for women as drinking more than seven drinks per week, more than three drinks per occasion, or any amount of consumption among those who are pregnant or at risk of pregnancy.

At-risk alcohol use results in multiple health effects, including unplanned pregnancy, sexually transmitted infections (STIs), altered fertility, menstrual disorders, and breast cancer, and greater risk of psychosocial problems, such as loss of primary relationships, sexual assault, and depression.

Survey research of ACOG Fellows revealed that more than half of respondents did not use screening tools to identify at-risk drinking, and many felt they did not have the time or training to effectively approach a patient who drinks at at-risk levels.

In late August, every active ACOG clinician will receive a laminated pocket card in the mail with tools you need to screen women, provide brief intervention and education, and refer patients for treatment when needed. All women seeking ob-gyn care should be screened for alcohol use at least yearly and within the first trimester of pregnancy. Screening can be done with simple validated tools during the routine visit. Just asking, “Do you drink alcohol?” is not enough. By using a validated tool, you can decrease patients’ false responses. Watch your mailbox for this resource, and let’s all use it.

In other news, The College has issued an update on breast cancer screening, and now recommends annual mammography for women starting at age 40. Also, this month ACOG applauds the preventive health services guidelines for women approved August 1 by the Department of Health and Human Services. Read about these topics inside this issue.
ACOG victory for women’s health

On August 1, the Department of Health and Human Services (HHS) accepted the Institute of Medicine’s (IOM) recent recommendations that require new health insurance plans to cover key preventive services for women at no cost to patients.

ACOG applauds this major victory for our patients. The women of this country deserve no less than access to all comprehensive and clinically effective preventive care. In today’s society, when many face day-to-day personal economic struggles, this action is good news for women’s health. Currently, more than half of American women report that they delay needed care due to cost, and many are unable to afford contraception in a nation where half of pregnancies are unintended.

The HHS decision is an example of the connection between the work ACOG is doing, and real improvements we are making for women’s health care. The sweeping health reform law, the Patient Protection and Affordable Care Act, requires qualified health plans to provide benefits without cost-sharing for preventive health care services. Soon after the law was enacted, the IOM was charged with defining these preventive services, and ACOG worked hard to encourage the IOM to rely on ACOG’s clinical guidance to determine what should be in the package. Our January testimony before the IOM provided evidence-based recommendations on what services would be covered and how policies would be written.

The HHS action addresses critical gaps in women’s preventive care that are not included under the US Preventive Services Task Force recommendations as Grade A or B services, the Bright Futures guidelines (developed by the Health Resources and Services Administration and the American Academy of Pediatrics), or the Advisory Committee on Immunization Practices guidelines.

The recommendations closely reflect ACOG’s guidelines, including: at least one annual well-woman preventive visit, including preconception care; intimate partner violence screening and counseling; HPV testing as part of cervical cancer screening; gestational diabetes screening for pregnant women; annual counseling for STIs; HIV screening and counseling for sexually active women; lactation support; and the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling.

Contraception is an essential component of women’s health care. Should a woman choose to use birth control, she should have access to all methods at no cost. The adoption of ACOG’s recommendations means essential care will be available to women in all socio-economic levels without co-payments, co-insurance, or deductibles. I am hopeful that our patients will experience a dramatic improvement in their lives as a result. Read more about this action on page four.

Hal C. Lawrence, III, MD
Executive Vice President

New position open to applicants: ACOG vice president, advocacy

Applications are due September 30

This newly created position is to be filled no later than February 1, 2012, with the intention that the individual will assume duties by July 1, 2012. Interested physicians must have an MD and/or DO degree and be currently certified by the American Board of Obstetrics and Gynecology, Inc. Requirements include experience in the practice of ob-gyn and government interaction at the state level. Government interaction at the federal level is desired but not required. Experience as an ACOG or College committee member or officer at the section, district, or national level is preferred.

Please send inquiries to VPSearch@acog.org and a job description and instructions for submitting an application will be sent to you. Applications must be received no later than September 30.
ACOG applauds no-cost coverage of women’s preventive care

The Department of Health and Human Services (HHS) has advanced health care for women, announcing new guidelines for private insurance coverage of key women’s preventive health care services at no added patient cost, as recommended in July by the Institute of Medicine (IOM).

“ACOG is pleased that these recommendations mirror many of ACOG’s recommendations on best preventive care practices for women’s health,” said Hal C. Lawrence III, MD, executive vice president of ACOG and The College.

In January, Dr. Lawrence testified before the IOM Committee on Preventive Services for Women, urging the panel to include core preventive health services for women based on ACOG guidelines. ACOG’s clinical practice recommendations have long been the leading guidelines for women’s health care.

The IOM package accepted by HHS includes:

- The full range of FDA-approved contraceptive methods, to help women control the timing, number, and spacing of births. (Planned pregnancies—which for most women require contraception—benefit women by allowing them to optimize their own health before pregnancy and childbirth. An unintended pregnancy may have significant implications for a woman’s health, sometimes worsening a preexisting health condition such as diabetes, hypertension, or coronary artery disease. Planned pregnancies improve the health of children as well because adequate birth spacing lowers the risk of low birth weight, preterm birth, and small-for-gestational age)
- At least one well-woman preventive visit, including preconception care, annually for adult women to obtain recommended preventive services, and allowing for additional visits, depending on the women’s health status, needs, and other risk factors
- Screening and counseling for intimate partner violence, which affects an estimated five million women a year
- Testing for HPV as part of cervical cancer screening
- Screening for gestational diabetes in pregnant women
- Annual counseling for sexually transmitted infections and counseling and screening for HIV in sexually active women
- Comprehensive lactation support and counseling, and costs of renting breastfeeding equipment

ACOG fully supported Senator Barbara A. Mikulski’s (D-MD) amendment to the Patient Protection and Affordable Care Act to guarantee women access to a full range of preventive health services without cost-sharing or deductibles. A 2009 Commonwealth Foundation report found that more than half of women delayed or avoided preventive care because of its cost. The HHS action to accept IOM’s recommendations will go a long way toward addressing this problem.


New warning on surgical mesh for pelvic organ prolapse

FDA cites serious complications

In July, the FDA issued a new safety communication on the serious complications associated with transvaginal placement of surgical mesh for pelvic organ prolapse (POP), identifying this as an area of “continuing serious concern.” The FDA is asking surgeons to consider carefully the risks and benefits of surgery with mesh versus all surgical and non-surgical alternatives and to make sure that patients are fully informed of potential complications from surgical mesh.

The College applauds the FDA’s effort in protecting women’s health by issuing an update to its 2008 Public Health Notification. In October 2010, The College leadership discussed similar concerns with high-level FDA staff. The College shares the FDA’s concerns and encourages patients and physicians to review the FDA’s white paper that provides additional background on surgical mesh materials, the FDA’s regulatory classification of mesh devices, a review of the current literature, and relevant FDA activities.

The College is pleased that FDA has scheduled a meeting September 8–9 of the Obstetrics Gynecology Devices Panel to discuss this issue, and appreciates FDA’s willingness to reconsider how it clears mesh products for marketing. It has been 10 years since FDA first cleared a mesh product for repair of POP. Since then, it has become apparent that rigorous comparative effectiveness research, including randomized trials of synthetic mesh and traditional non-mesh (native tissue) repair, performed with long-term follow-up, is essential to prove product safety and efficacy.

In the safety communication, FDA summarizes the adverse events reported through its Manufacturer and User Device Experience (MAUDE) database and described in the peer-reviewed literature; makes recommendations for providers and patients; and explains how to report problems to the FDA. This communication focuses solely on mesh for POP, not mesh for stress urinary incontinence.

After reviewing its MAUDE database for 2008–2010, the FDA identified 1,503 medical device reports of adverse events with surgical mesh repair of POP, reflecting more than a continued on page 8
The College issued new breast cancer screening guidelines this month recommending mammography screening be offered annually to women beginning at age 40. Previous College guidelines recommended mammograms every one to two years starting at age 40 and annually beginning at age 50.

According to Jennifer Griffin, MD, MPH, who co-authored The College guidelines, the change in mammography screening for women beginning at age 40 is based on three factors: the incidence of breast cancer, the sojourn time for breast cancer growth, and the potential to reduce the number of deaths from it. Although the sojourn time – between when a breast cancer may be detected by a mammogram while it is very small and before it grows big enough to become symptomatic – can vary, the greatest predictor is age. Women ages 40–49 have the shortest average sojourn time (2–2.4 years), while women ages 70–74 have the longest average sojourn time (4–4.1 years).

"Although women in their 40s have a lower overall incidence of breast cancer compared with older women, the window to detect tumors before they become symptomatic is shorter, on average," said Dr. Griffin. The five-year survival rate is 98% for women whose breast cancer tumors are discovered at their earliest stage, before they are palpable and when they are small and confined to the breast. "If women in their 40s have annual mammograms, there is a better chance of detecting and treating the cancer before it has time to spread than if they wait two years between mammograms."

The College continues to recommend annual clinical breast exams (CBE) for women ages 40 and older, and every one to three years for women ages 20–39. Additionally, The College encourages "breast self-awareness" for women ages 20 and older. Enhanced breast cancer screening, such as more frequent CBEs, annual MRI (magnetic resonance imaging), or mammograms before age 40, may be recommended for women at high risk of breast cancer. Breast MRI is not recommended for women at average risk of developing breast cancer.

Breast cancer is the second leading cause of all cancer-related deaths among American women. The incidence of breast cancer in the US declined 2% each year between 1999 and 2006, and deaths from breast cancer have also declined steadily over the past two decades. Evidence suggests the drop in breast cancer rates is most likely due to fewer women getting mammograms and therefore not being diagnosed, as well as a significant drop in women using hormone therapy for menopausal symptoms. "The good news is that fewer women are dying from breast cancer because of earlier detection and improved treatments," said Gerald F. Joseph, Jr, MD, vice president of Practice Activities for The College.

The College’s breast cancer screening guidelines also address clinical breast exams and breast self-awareness.

Clinical breast exams
Studies on CBEs suggest they can help detect breast cancer early, particularly when used along with mammograms. Thus, The College recommends that women ages 40 and older have an annual CBE performed by their physician. Although the benefit of CBEs isn’t clear for those younger than age 40, The College continues to recommend that women ages 20–39 have a CBE every one to three years.

Breast self-awareness
The traditional breast self-exam (BSE) has shifted toward a newer concept called “breast self-awareness.” BSE is performed in a systematic way on a regular basis, typically monthly. Breast self-awareness, on the other hand, is women understanding the normal appearance and feel of their breasts, but without a specific interval or systematic examination technique. The College endorses educating women ages 20 and older regarding breast self-awareness.

"The goal here is for women to be alert to any changes, no matter how small, in their breasts, and report them to their doctors," said Dr. Griffin. "Although we’ve moved away from routinely recommending BSEs, some women will want to continue doing them and that’s OK.”

According to The College, there is no consensus on the upper age limit for mammograms, although the benefits of screening declines with increasing age compared with the harms of overtreatment. Women ages 75 and older should discuss with their doctor whether to continue getting mammograms, said Dr. Griffin.

Women and alcohol: How much is too much?

Women have unique vulnerabilities to alcohol that men do not have, and the significant risks they face from inappropriate use and abuse of alcohol range from pregnancy complications and long-term damage to their children to an increased risk of breast cancer and the danger of sexual assault and sexually transmitted infections.

When Diana Cheng, MD, first began working with the Maryland Department of Health and Mental Hygiene, she was surprised at the results that were coming in from the state’s annual Pregnancy Risk Assessment Monitoring System (PRAMS) survey, which among other issues, studies alcohol consumption and risk surrounding pregnancy.

“About 30% of women patients reported to us that they weren’t given counseling by their ob-gyn about alcohol and the impact it could have on a pregnancy,” Dr. Cheng marveled. “And fully 20% of them weren’t even asked if they drank alcohol during their pregnancy. We were very alarmed by that.”

The Maryland PRAMS survey, whose findings appeared in the Green Journal in February 2011, demonstrates that many ob-gyns are not screening women for alcohol problems, even during such a high-stakes time as in pregnancy. “For a provider, it is not effective to just briefly ask a patient, ‘Do you drink alcohol?’ and then check a yes-or-no box,” said Patrick S. Ramsey, MD, MSPH, with Texas Perinatal Group and adjunct associate professor of maternal/fetal medicine with Uniformed Services University of the Health Sciences and University of Texas School of Public Health. “Ob-gyns need to use validated screening tools.”

A new College document, At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications, Committee Opinion #496, points out that real alcohol screening—not lip service—is a crucial responsibility of physicians, and ob-gyns must make a substantial effort to learn techniques for rapid, effective screening as well as brief intervention, patient education, and referral for their patients who drink alcohol at at-risk levels.

Understanding the risks
Alcohol and pregnancy

In October 2010, a British study published in the Journal of Epidemiology and Community Health seemed to contradict the common understanding that there is no safe level of drinking during pregnancy. Looking at five-year-olds whose mothers had had no more than one or two glasses of wine a week during pregnancy, the researchers found no negative effects of such light drinking.

This study confused both women and doctors, said Dr. Cheng, who
noted that in Maryland at least, the number of women who admit to drinking during pregnancy has steadily increased.

“Now, 10% of women say they drank alcohol during the last three months of pregnancy,” she said. “And 2% of women admit to binge drinking during pregnancy, which is probably even more risky. For women who were already ambivalent about abstinence during pregnancy, this study made them more ambivalent.”

“While we can’t prove that small amounts of alcohol during pregnancy are harmful, it’s like playing with matches near the ammunition depot: Why risk it?” asks Jacqueline Starer, MD, chairperson of the American Society of Addiction Medicine’s Work Group on Women and Substance Use Disorders. “We don’t know what the safe level is, if there is any. Certainly, during the organogenesis stage, even a very small exposure to alcohol can cause harm during a critical time of organ development.”

Approximately 40,000 babies every year are born with some sort of after-effects from a mother’s alcohol use during pregnancy, said Dr. Ramsey. “That’s a lot of babies. It’s not all fetal alcohol syndrome (FAS), the most severe form of alcohol spectrum disorders. Even smaller doses of alcohol can lead to behavioral disorders and mental handicaps that fall short of true FAS.” This broader umbrella of cognitive, learning, and behavioral disabilities is known as FASD, fetal alcohol spectrum disorder.

**Breast cancer and other risks**

Alcohol and health can be a double-edged sword. A number of studies have suggested that moderate alcohol consumption—generally defined as one drink (5 ounces of wine, 1.5 ounces of hard liquor, or one 12-ounce beer) per day for women, and two such drinks for men—can have a protective effect against heart disease.

However, as noted in The College’s new Committee Opinion, data indicate that women who drink between two and five drinks per day may have up to a 41% increased incidence of breast cancer, and risk increases linearly with consumption throughout this range. Women who have already survived breast cancer need to be particularly on guard. Last year, a prospective study involving nearly 2,000 women diagnosed with early-stage breast cancer, published online August 30 in the *Journal of Clinical Oncology*, found that drinking at least two glasses of wine per week was associated with an increased risk of both recurrence and death from breast cancer.

Alcohol use may exacerbate depressive symptoms, and acute alcohol use is associated with suicide. High rates of positive blood alcohol concentrations have been found among suicide victims.

**Sexual assault and STIs**

When women drink, they can fall prey to “telescoping”—a term meaning they encounter the behavioral and medical consequences of alcohol much more quickly than men. “They don’t metabolize alcohol as well as men do, so everything that can happen as a result of drinking happens faster to women than to men,” said Dr. Starer.

And that can often put women at risk of being victimized. Binge drinking (defined for women as consuming more than three drinks per occasion or more than seven drinks per week) is on the rise among US women, according to the Centers for Disease Control and Prevention: From 1999–2002, binge drinking by women in the 18–44 age group increased nationally by 13%. Among 18–34-year-olds who binge drink, almost one-third report drinking eight or more drinks per occasion. Many studies have found that anywhere from 30–50% of college-age women binge drink.

The consequences can be devastating. Alcohol is involved in 90% of campus rapes, according to Columbia University’s National Center on Addiction and Substance Abuse. Women who binge drink also engage more often in risky sexual behaviors, leading to more frequent cases of sexually transmitted infections. Women who binge drink are five times more likely to have gonorrhea, for example.

“Drinking excessively makes women vulnerable,” said Dr. Starer. “It impairs their judgment and they get into dangerous situations that they may not even remember. Ob-gyns need to educate their patients about the risks involved in this kind of drinking.”

**How to screen?**

Many ob-gyns are uncomfortable asking their patients about alcohol consumption, fearing that they will be seen as judgmental. Dr. Starer said one way around that concern is to incorporate alcohol screening into general history taking.

“I personally have found that the most successful way to get the information is to work my way in through the family history,” she said. “Rather than starting right out by asking a patient, ‘Do you drink?’ I’ll ask about alcohol in the family history, which people are much more willing to talk about. If you let them talk, often they’ll bring it around to themselves.”

The new Committee Opinion guides ob-gyns in talking to patients about alcohol use and includes screening tests that identify at-risk drinking.

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**TACE SCREENING TOOL**

| T – Tolerance: How many drinks does it take to make you feel high? (More than 2 drinks = 2 points) |
| A – Annoyed: Have people annoyed you by criticizing your drinking? (Yes = 1 point) |
| C – Cut down: Have you ever felt you ought to cut down on your drinking? (Yes = 1 point) |
| E – Eye-opener: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Yes = 1 point) |

A total score of 2 points or more indicates a positive screening for at-risk drinking.

A mesh procedure may put the patient at risk for requiring additional surgery or for the development of new complications.

> Removal of mesh due to mesh complications may involve multiple surgeries and significantly impair the patient’s quality of life. Complete removal of mesh may not be possible and may not result in complete resolution of complications.

> Mesh placed abdominally for POP repair may result in lower rates of mesh complications compared to transvaginal POP surgery with mesh.

> Inform the patient about the benefits and risks of non-surgical options, non-mesh surgery, and surgical mesh placed abdominally and the likely success of these alternatives compared to transvaginal surgery with mesh.

> Notify the patient if mesh will be used in her POP surgery and provide the patient with information about the specific product used.

> Ensure that the patient understands the post-operative risks and complications of mesh surgery as well as limited long-term outcomes data.

**What should you do?**

Be prepared for questions from patients who have had surgery to repair POP. The guidance in the safety communication may help ensure the safety and effectiveness of transvaginal placement of mesh for POP, and this guidance can be useful to Fellows in counseling patients. The FDA’s white paper provides important summarized information on mesh, and The College suggests that Fellows read the document.

The College’s Practice Bulletin #85, *Pelvic Organ Prolapse* (reaffirmed in 2009), addresses the risks and complications of transvaginal placement of mesh for POP. The College notes that “given the limited data and frequent changes in the marketed products for vaginal surgery for prolapse repair (particularly with regard to type of mesh material itself, which is associated with several of the postoperative risks, especially mesh erosion), patients should consent to surgery with an understanding of the postoperative risks and complications and lack of long-term outcomes data.”

Fellows should follow the emerging literature closely to remain knowledgeable about which techniques and products should be avoided and which are ultimately proved to be of benefit.
There isn’t enough good evidence to support routinely screening all pregnant women for vitamin D deficiency, according to The College’s new Committee Opinion, Vitamin D Screening and Supplementation During Pregnancy. Most pregnant women can help ensure they’re getting enough vitamin D through prenatal vitamins. Women can also obtain vitamin D through fortified milk and juice, fish oils, and dietary supplements.

“Recent data suggests that vitamin D deficiency is common among pregnant women, particularly among high-risk groups such as vegetarians, those who have limited exposure to the sun, and women with darker skin tones,” said George A. Macones, MD, chair of The College’s Committee on Obstetric Practice.

Some proponents have suggested that all pregnant women should be screened for vitamin D deficiency. The problem, said Dr. Macones, is that there is no consensus on what the optimal level of vitamin D should be during pregnancy, nor is it known what the upper limit is in terms of the safety of supplemental doses. The College recommends that only those pregnant women thought to be at increased risk for vitamin D deficiency be tested. Most experts agree that supplementation of 1,000–2,000 IU a day is safe for pregnant women who are clinically deficient in vitamin D. “Anything higher than this has not been studied,” Dr. Macones said.

Until the results of the ongoing randomized clinical trials on vitamin D are completed, most pregnant women can get sufficient vitamin D through sun exposure and perhaps taking prenatal vitamins, said Dr. Macones. Committee Opinion #495, Vitamin D Screening and Supplementation During Pregnancy, is published in the July 2011 issue of the Green Journal and is online under Publications at www.acog.org.

When attempting to become an author, it is said: “Write what you know.” For ACOG Fellow Darden H. North, MD, of Jackson, MS, that meant reaching beyond 24 years of general ob-gyn practice to delve into cut-throat medical politics, sexual discrimination, arson, stolen frozen human embryos, multiple murder scenarios (some with a mistaken identity twist), and most recently, international terrorism.

Dr. North, a full-time partner in a 15-member, single specialty ob-gyn group, is the author of three nationally-awarded medical mystery novels set in the South and is nearing completion of his fourth book. He discovered his talent for writing about 20 years ago when he simply chose to give it a try.

“I saw a scarcity of physicians writing fiction, particularly practicing physicians, and none of them were Southern,” Dr. North said. “First, I decided I could write. Then, my family and friends egged me on. And finally, the 8,000 people who bought my first novel were a sign to keep going.”

On his time off from practice, Dr. North travels to book signings, writing conferences, and other promotional events. He squeezes in research and writing for his books whenever he can.

“Authors need to meet their readers and get to know them,” he said. “Just like a doctor needs to have a great bedside manner, so too does an author need to be personable and likeable, as well as professional and talented.”

At home, Dr. North finds that his patients are some of his biggest supporters.

“I cannot ignore that my patient base has given me a jump start with book sales, and I am thankful,” Dr. North said. “My patients and colleagues read my books and give them as gifts. I think everyone has a book in his or her heart, and when you meet or know someone who has actually written one, there is a desire to become part of the adventure.”

More information about Dr. North and his novels can be found at www.dardennorth.com.

Excerpted from an interview with J. Martin Tucker, MD, District VII newsletter editor. To read the full article, go to www.acog.org/goto/dardennorth.
Are you screening for sexual assault?

Health care providers should routinely screen all patients for a history of sexual assault, according to a Committee Opinion issued this month by The College. More than 300,000 women are sexually assaulted each year in the US, but this number likely underestimates the prevalence of sexual assault as it is one of the least reported violent crimes.

The term sexual assault covers a range of unwanted or forced sexual activity, from inappropriate touching to rape. Many women are not upfront about their experiences with sexual assault due to stigma associated with the crime and/or fear of retaliation if they report it. Most often, women know the person assaulting them.

“When ob-gyns routinely screen patients for a history of sexual assault, women who have been or are currently being assaulted may be more likely to report their abuse,” said Veronica Gillispie, MD, a member of The College’s Committee on Health Care for Underserved Women who helped develop the Committee Opinion. “There is a long list of physical and emotional health problems that follow a history of abuse. By identifying victims of sexual assault and encouraging them to report their abuse, these problems can be better addressed and even prevented.”

Sexually assaulted women are at risk for unintended pregnancy, sexually transmitted infections (STIs), and physical injuries ranging from scratches, bruises, and welts to broken bones, bullet wounds, and even death. Sexual assault is also associated with mental health conditions, such as post traumatic stress disorder and substance abuse and dependence.

The College emphasizes that emergency contraception and preventive measures for STIs should be available and provided to women who have been sexually assaulted. In addition, physicians examining these women have a responsibility to be familiar with forensic examination procedures and state and local policy requirements for gathering evidence of assault.

“Ob-gyns can be instrumental in stopping the cycle of abuse,” Dr. Gillispie said. “Providers should understand their role in treating patients with a history of sexual assault and how important they can be in helping these women heal.”

Committee Opinion #499, Sexual Assault, is published in the August 2011 issue of the Green Journal and is online under Publications at www.acog.org.

IUDs, implants are most effective reversible contraceptives available

Long-acting reversible contraceptive (LARC) methods—namely intruterine devices (IUDs) and implants—are the most effective forms of reversible contraception available and are safe for use by almost all reproductive-age women, according to a Practice Bulletin released in July by The College. The new recommendations offer guidance to ob-gyns in selecting appropriate candidates for LARCs and managing clinical issues that may arise with their use.

“LARC methods are the best tool we have to fight against unintended pregnancies, which currently account for 49% of US pregnancies each year,” said Eve Espey, MD, MPH, who helped develop the new Practice Bulletin.

More than half of women who have an unplanned pregnancy were using contraception. The majority of unintended pregnancies among contraceptive users occur because of inconsistent or incorrect contraceptive use. LARCs have the highest continuation rates of all reversible contraceptives, a key factor in contraceptive success.

New guidance on use of IUDs and implants includes the following:

- Nulliparous women and adolescents can be offered LARC methods, including IUDs
- Current data do not support routine screening for sexually transmitted infections (STIs) before IUD insertion for women at low risk of STIs
- For women at high risk of STIs, it is reasonable to screen for STIs and place the IUD on the same day (and administer treatment if the test results are positive)
- Routine antibiotic prophylaxis to prevent pelvic infection is not recommended before IUD insertion
- Insertion of a copper IUD is the most effective method of postcoital contraception when inserted up to five days after unprotected sex
- Immediate postpartum IUD insertion, which is an insertion within 10 minutes of placental separation, appears safe and effective
- Insertion of an IUD or an implant may occur at any time during the menstrual cycle as long as pregnancy may be reasonably excluded

Despite the many benefits of LARC methods, the majority of women in the US who use birth control choose other methods. Fewer than 6% of women in the US used IUDs between 2006 and 2008. According to The College, lack of knowledge about LARCs and cost concerns may be to blame. “Women need to know that today’s IUDs are much improved from earlier versions, and complications are extremely rare. And while upfront costs may be higher, LARCs are much more cost-effective than other contraceptive methods in the long run,” Dr. Espey said.

The College encourages Junior Fellows to submit their projects, due November 30, for the Junior Fellow Initiative Toolkit (JFIT) Contest. Enter descriptions of notable educational or community service projects, including advocacy and recruitment projects. All will be posted on the Junior Fellow web pages at www.acog.org so others can duplicate them. The winner will receive a $2,500 prize for travel and expenses to present his or her project at the 2012 ACM in San Diego, May 5–9.

Serve your community and be a winner: Enter the JFIT contest

Welcome, new incoming Junior Fellow district chairs

District I, Katharine Esselen, MD
District II, Randi D. Leigh, MD
District III, Aasta D. Mehta, MD
District IV, Jill M. Krupf, MD
District V, Rebecca I. Epstein, MD
District VI, Evelyn Rodriguez, MD
District VII, David R. Ellington, MD
District VIII, Margaret P. Maeder, MD
District IX, Megan L. Stephenson, MD
Armed Forces District, Deanna McCullough, MD
District XI, Meadow M. Good, DO

Junior Fellow district chairs offer guidance, leadership, and inspiration. Contact your new district chair to learn more about The College’s resources for Junior Fellows and opportunities to get involved.

Find information about Junior Fellow activities at www.acog.org. Click on Junior Fellows.

Get ready to attend your ANNUAL DISTRICT MEETING

September
22–24    District V, Detroit, MI
23–25    District VII, Kansas City, MO

October
13–16    District III, Philadelphia, PA
14        District III Junior Fellows, Philadelphia, PA
14–16    District I, Halifax, Nova Scotia, Canada
14–16    District XI, Plano, Texas
21–23    District IV, Naples, Florida
23–26    Armed Forces District, San Diego, California
28–30    District II, New York
26–29    District VI, Nassau, Bahamas
28–30    District VIII and District IX, Los Cabos, Mexico
MAKING the Rounds

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<td>ACOG Coding Workshop, Chicago, IL</td>
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<tr>
<td>DECEMBER 1–3</td>
<td>Update on Cervical Diseases, New York, NY</td>
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<tr>
<td>DECEMBER 2–4</td>
<td>ACOG Coding Workshop, Atlanta, GA</td>
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<tr>
<td>DECEMBER 2–4</td>
<td>Practical Obstetrics and Gynecology, Chicago, IL</td>
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<tr>
<td>DECEMBER 13</td>
<td>ACOG Webcast: Preview of New Codes for 2012</td>
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