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Documentation of reproductive health counseling and contraception in women with inflammatory bowel diseases☆

Lori M. Gawron [a,*], Cassing Hammond [a], Laurie Keefer [b]

[a] Department of Obstetrics and Gynecology, Northwestern University, Chicago, USA
[b] Division of Gastroenterology and Hepatology, Department of Medicine, Northwestern University, Chicago, USA

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ABSTRACT

Objective: Inflammatory bowel diseases (IBD) are commonly diagnosed during women's reproductive years. Counseling is important to avoid unintended pregnancy in a disease-poor state. We sought to determine reproductive counseling documentation by gastroenterologists in women with IBD.
Methods: An electronic query identified women, age 18–45, with IBD in an academic gastroenterology practice from 2010 to 2012. A random sample (15%) chart review determined contraception documentation and content/frequency of reproductive counseling.
Results: 100 patients were analyzed. Median age was 35 (range 19–45), 53% were married, and 69% had Crohn's disease. Median time since IBD diagnosis was 9 years (range 1–32) with a 5 visit median (range 1–45) over 31 months (range 1–105). A contraceptive method was identified in 24% of all patients.

Nineteen patients (19%) had documentation of reproductive counseling. Only 1/100 patients had a specific reference to using contraception to avoid pregnancy. The remaining counseling included (1) medication effects on pregnancy, (2) disease control before pregnancy, or (3) mode of delivery planning.
Conclusions: Outside of listing contraception as a "current medication", documentation of reproductive counseling at gastroenterology visits for IBD is sparse.
Practice implications: In light of the importance of reproductive planning for women with IBD, future research on incentives and barriers to counseling is warranted.

1. Introduction

Pregnancy planning and contraception non-adherence are substantial public health concerns in the United States, with over half of all pregnancies being unintended each year [1]. A reduction of the unintended pregnancy rate is a specific goal of Department of Health and Human Services' Healthy People 2020 campaign [2]. Physician counseling has been shown to alter maternal behaviors to improve pregnancy outcomes and decrease the risk of an unintended pregnancy through increased uptake of effective contraceptive methods; goals that take on additional significance for women with chronic medical conditions [3,4].

Inflammatory bowel diseases (IBD) are chronic relapsing and remitting disorders that are primarily comprised of ulcerative colitis and Crohn's disease. IBD is commonly diagnosed during women's reproductive years, with the highest incidence of disease onset between 20 and 29 years of age [5]. An unintended pregnancy in a woman with IBD may be detrimental due to the risk of adverse pregnancy outcomes in a poorly controlled disease state, potential teratogenic medication exposures or delay in IBD treatment options. Approximately 25% of women with IBD conceive for the 1st time after disease diagnosis [6]. The disease itself does not affect overall female fertility rates, although two studies have shown an increased rate of voluntary childlessness and smaller family size than the general population [7–12]. Concerns regarding IBD heritability, congenital malformations, medication teratogenicity or a physician's recommendation to avoid pregnancy influenced family planning choices by women with IBD [12]. Increases in the spontaneous abortion rate, preterm delivery, and low-birth weight have all been related to the activity of the disease at the time of pregnancy [13–15]. Women desiring pregnancy may opt to defer more aggressive/high-risk treatments such as surgery or biological therapies until after family completion [16]. Given the risk of relapse and adverse pregnancy outcomes, women may be advised to achieve pregnancy only after six months of remission [17].

The 2010 Centers for Disease Control's United States Medical Eligibility Criteria confirms hormonal contraception is safe and highly effective for pregnancy planning in women with IBD [18]. The National Survey for Family Growth in 2006–2008 found that

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* Corresponding author at: 680 N. Lakeshore Drive Suite 1015, Chicago, IL 60611, USA. Tel.: +1 312 695 4373; fax: +1 312 695 8711.
E-mail address: lgawron@northwestern.edu (L.M. Gawron).

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99.1% of women age 15–44 who had ever had intercourse reported using contraception at some point [19]. Despite the risks of unintended pregnancy, women with IBD have been shown to utilize contraception at rates slightly lower than the general population, with few women with IBD using highly effective contraceptive methods [11].

Women with IBD seek information regarding pregnancy and contraception from their gastroenterologist more frequently than their primary care physician [12]. A recent Irish study found that 42% of respondents with IBD felt their disease influenced family planning decisions, yet 68% had not discussed family planning with a doctor [20]. Literature is lacking on the nature and extent to which family planning issues are discussed in routine IBD patient encounters by gastroenterologists. The objectives of this study were to determine the frequency of contraceptive method documentation and the frequency and content of reproductive health counseling by academic gastroenterologists in reproductive age women with IBD.

2. Materials and methods

Women, age 18–45, with ulcerative colitis or Crohn's disease who accessed care within a practice of thirteen academic gastroenterologists from 2010 to 2012 were identified by an electronic query of the Enterprise Data Warehouse at Northwestern University. A manual chart review was performed in October 2012 to confirm the diagnosis of Crohn's disease or ulcerative colitis and characterize documentation of care within the gastroenterology faculty practice. Women with an indeterminate diagnosis or history of a hysterectomy were excluded. A random sample of 100 women was identified through a computerized random numbers generator.

A manual chart review was completed on all gastroenterology visits to determine the following: (1) participant demographics and disease characteristics, (2) proportion of participants receiving IBD medications within the United States Food and Drug Administration Category C (animal studies have shown adverse outcomes, but there are no well-designed human studies), Category D (there is positive evidence of human fetal risk, but benefits may outweigh risks), or Category X (there is positive evidence of human fetal risks and the risks outweigh any benefits of use in pregnancy), (3) documentation of contraceptive method, and (4) content and frequency of documented reproductive health counseling. Following data extraction, all data were de-identified, entered into Microsoft Excel spreadsheet software 2010 and analyzed. Descriptive statistics were performed with the assistance of SPSS v20 and reported as proportions and medians. This study was approved by the Institutional Review Board at Northwestern University.

3. Results

A total of 638 reproductive-age IBD patients were identified through the electronic query and confirmed to meet inclusion criteria. A random sample of 100 women (15%) was identified and a detailed manual chart review was performed. No significant difference was found in median age or disease type proportion between the random sample and the total study population and all physicians in the practice were represented. The median age of participants was 35 (range 19–45) and 53% were married. Crohn's disease represented 69% of the diagnoses and 31% of the participants had ulcerative colitis. The median time since IBD diagnosis was 9 years (range 1–32) and 29% of the women had previous IBD-related surgery. The median number of gastroenterology visits was 5 (range 1–45) over 31 months (range 1–105), with the earliest visit in December 2003 and last in September 2012. Contraceptive method was documented in 24% of patients' charts in at least one visit; however, this coincided only with hormonal methods that were listed as a medication (Table 1).

Table 1
Participant characteristics ($n = 100$).

IBD diagnosis	
Crohn's disease	61%
Ulcerative colitis	39%
Demographics	
Current median age (range)	35 (19–45)
Race	
White	71%
Black	12%
Asian	3%
Unknown	14%
Hispanic ethnicity	
Yes	3%
Unknown	11%
Insurance type	
Private	87%
Public (Medicaid/Medicare)	12%
Uninsured/self-pay	1%
Married	53%
Disease characteristics	
Median no. years since diagnosis (range)	9 (1–32)
Previous IBD surgery	29%
Median no. months in faculty practice (range)	31 (1–105)
Median no. visits in faculty practice (range)	5 (1–45)
Contraception	
Documented contraceptive method	24%
Combined hormonal method (pill, patch, ring)	79.2% (19/24)
Levonorgestrol intrauterine contraceptive	16.7% (4/24)
Depo-Provera injectable	4.1% (1/24)

Of the 100 patients identified, 48% used a Category D and 6% used a Category X medication for IBD management. The majority of patients used Category B or C medications. A contraceptive method was documented in the gastroenterology visit in 29.2% ($n = 14/48$) of Category D and 16.7% ($n = 1/6$) of Category X medication users (Table 2).

Nineteen patients (19%) had reproductive health counseling documented in at least one physician's note. Only 1/100 patients had a specific reference to using contraception to avoid pregnancy; she was on a category X medication, but no contraceptive method or plan was found in her chart. The remaining counseling was related to (1) stopping medications for pregnancy/breastfeeding ($n = 10$), (2) improving disease control before pregnancy ($n = 6$), or (3) planning for mode of delivery ($n = 2$). Only 3 of the 19 patients (15.8%) had physician-initiated discussions about avoidance of pregnancy or disease management prior to considering pregnancy. The remaining 16 patients were either already pregnant or initiated a discussion due to their plans for future pregnancy.

4. Discussion and conclusion

4.1. Discussion

In a random sample of 100 reproductive age women with IBD who are potentially at risk for pregnancy, only 24% had a contraceptive method documented and 19% had reproductive health documentation in the chart by her gastroenterologist. The only documented contraceptive methods were those that could be considered a "medication," such as a pill or hormonal intrauterine device, therefore, the medical assistant may have populated the medication list with this information. The women who require a Category D or X medication have the greatest risk of teratogenic effects and an increased need for reproductive planning due to disease severity, yet also had scant contraceptive documentation. The addition of a separate area for contraceptive documentation outside of the medication lists in electronic medical records may