all right good evening everyone um I just wanted to welcome you to the um JOWMA women's health committee webinar focusing on family planning my name is Nicole feigenbloom I am a fourth year medical student Hackensack Meridian School of Medicine and we'll be starting my obstetric and Gynecology residency this upcoming July I'm also one of the chairs of the women's health committee and will be moderating tonight's event thank you so much for what for registering for our webinar tonight we plan to address the following topics firstly contraception including indications types benefits and risks as well as providing an overview of abortion care terminology and facts as well as medical and procedural forms of determination there will be a q a at the end of the event please keep all your questions broad all questions should be posed in the question and answer or the Q a box when asking the questions please hit remain anonymous button in the bottom left hand corner your presence on the webinar is completely Anonymous in your video and voice are not enabled and attendings cannot be viewed so first we're going to have Dr Hellman speak Dr Alyssa Hellman is an experienced board certified OB GYN she received her medical degree from New York NYU school of medicine and completed her residency at North Shore University Hospital in Long Island In Obstetrics and Gynecology Dr Hellman has been been in clinical practice for over 12 years in Milwaukee Wisconsin she is also a physician at The Confident kala a telemedicine Gynecology practice focused on health needs for Jewish women throughout her career she noticed a gap in women's health awareness and knowledge this developed into a special interest in patient education and being a resource for the Jewish community in relation to body awareness and women's preventative health with that I give you Dr Alyssa Hellman all right hi everyone thanks so much for being here um let me just share my screen and we'll get right to it this talk I usually give in like an hour hour and a half but we are going to condense it and there will be questions at the end all right so today I am going to talk about everything related to contraception or in other words birth control and um you know when I when I do talk about birth control I um you know it's kind of helpful to think about it in different categories um so what options there are like there are so many so let's kind of organize them in our minds um of what's available um and like how do they work and what that means for you and and like what your experience will be on them um and then kind of really understanding the pros and cons of both because that's really kind of what drives um your decision of what you may end up using so I think the most the easiest way to kind of categorize them for ourselves is um and then our model and in the hormonal category we have two progesterone only and combined hormonal which means both estrogen and progesterone um and we will go over all of these things but you can see that there are a bunch of options in each category so we are going to start with non-hormonal so kind of the overriding you know similarity of all of these is that a non-hormonal contraceptive maintains our usual cycle so there are no hormones in it that are somehow manipulating or controlling um or overriding your own menstrual cycle hormonal fluctuations foreign so I always like to start off the birth control conversation with the contraceptive plan of psycho awareness method and this can be used both to be aware of your fertility to try and get pregnant but also to be aware of your fertility to try and avoid pregnancy and this involves um kind of multiple um kind of ways of of being aware of this so it's using a calendar it's using an app kind of being aware of what your average cycle is how long your periods are when you think they may come using physical signs like cervical mucus changes temperature changes sometimes we can be a little more like scientific about it and test um that you can get in the um in the pharmacy called ovulation predictor kits and kind of use all of these things to kind of know when ovulation is happening why do we care about that because that's when we either avoid intercourse or use something like a spermicide or some more episodic type birth control to avoid pregnancy at that time that we're aware of that we are in our fertile um in our fertile time of our cycle

and this obviously takes a lot of awareness a lot of like checking and tracking um so usually is iron maintenance than others but some people feel very comfortable with it and some people are like I cannot manage this this is too much for me the next um non-hormonal birth control look over is um a spermicide method so there's kind of two ways to do this and these are um um like little I guess not devices but you know creams or ointments or gels or Foams that you put inside the vagina before having sex so every time beforehand um and the kind of more standard one um is known as nanoxton nanoxinol nine um and it it's literally a spermicide it kills the sperm when it comes in contact to it um in the within the vagina itself um it's not prescription you can walk into a drugstore you can walk into Target and just buy it um and you need to place it about an hour before intercourse um main side effect is sometimes a little bit of vaginal irritation but sometimes this works really well for people especially if they're using it like with the cycle awareness method um just in that week that they know that they're generally more fertile another kind of newer prescription option is something called sexy and it kind of Acts similarly where it's put into the vagina I'm injected with a little applicator here it's like a little gel um and it's put in before like an hour before sex and it's basically instead of killing the sperm it acidifies the vagina more sperm does not like an acidic environment and it um it kind of inactivates them like they just they don't like it um so they really can't function well and they don't get a swim up into the cervix through the uterus into the fallopian tube where fertilization would happen so that's how that works um it's a little bit on the pricey side because it's not off of patent yet because it's new but um one day I'm sure it will be cheaper um and these are not like the most effective we can get because they require a lot of personal responsibility they're required to be put in a certain time before the ejaculation were to happen um and sometimes all that stuff doesn't work out perfectly so um they're not 100 um perfect more like in the mid to high 80s okay the next one which is I'd say not super common in the US um use I think more so um out of this country um is the Kaya diaphragm um and I will say that we I've been now I mean for my bio I've been out you know about 13 years or so and there's really not there not such great training these days in using a diaphragm because it's really as we get more and more um hormonal birth controls available it's kind of gone out of favor because it is a little bit high maintenance um it is a little kind of like silicone device that you put inside the vagina it covers the cervix right so it's supposed to kind of like prevent be a blockage preventing the sperm than the ejaculate to getting into the cervix you do need to put a spermicide around it um so it's kind of like a little extra protection along with the spermicide it really you need to make sure that it fits well within the vagina itself and there's not going to be a lot of space around it um this one was designed to be one size fits most so a little bit different than the older diaphragms that came in multiple different sizes that you would go to the gynecologist and get fitted for but again like some people feel like this really works for them um just like using the like spermicide or flexi um and it's just kind of like a little added layer of protection in the U.S you need a prescription for it and you pick it up at the pharmacy and then you go kind of getting it get it fitted in the doctor's office just to make sure that it's like the right size um the last kind of non-hormonal option we'll talk about is the paragard IUD um and it has copper as the active ingredients in other countries they do have other iuds that are shaped differently that also have copper in the active ingredient um I think in Israel they have some that are like copper balls um but this is kind of what we have here in America um and what the copper is doing is really creating a inflammatory reaction very localized not systemic but very localized within the uterine lining sperm does not like that it's very like inhospitable to the sperm so again the sperm does not get into the fallopian tube which like on this little diagram would be like right here where the egg would be and that's where it would be fertilized so it's kind of blocking it by creating this inflammation um that inflammation itself can also affect the periods because that's what is getting

inflamed so periods can sometimes be a little longer heavier a little bit crampier um so it's great for someone who maybe has kind of super light regular um you know just three day long periods not great for someone who to begin with has like seven day long heavy periods because then they'll just get like longer and heavier there can be some as everybody gets used to there can be some spotting between it so I think that's kind of like a misunderstanding between this and some of the progesterone iuds where um there is more often some spotting with this one even though it's not hormonal you can still get some spotting and it can take a little bit of time to adjust it does last for 10 years it can come out at any time so people will often use these between children um like for spacing or when they think that they're done having kids for that long term you know I don't want to take a pill every day um and even beforehand too um um if they feel like they have that contraceptive need um this is purely a contraceptive though there is no other like advantage to the cycles also very um very effective right put it in there's no responsibility like once it's in you it's in you and it's working it is important that the copper iuds be placed properly if it's sitting too low there is a higher chance that it's not going to work as well all right and then barrier method so since we're JOWMA here I'll just add my little plug that these very often are not um are not really used very much in Judaism they're definitely like in within the realm of Allah there does happen to be a very um you know circumstances where they are used but I will just kind of put that as a little caveat so there's condoms um these are again kind of like that episodic birth control where they um before having sex before um penetration a like kind of latex or non-latex sheath is placed over the penis so that the ejaculate is collected in there and does not go into the woman so that there's no sperm in the woman to then fertilize an egg um and then there's also permanent sterilization which is a surgical option um where the women's Fallopian tubes get cut or removed um and that prevents the egg that cuts coming out of the ovary which then would get usually swept up into the fallopian tube and get fertilized within the fallopian tube um that that traveling path is now gone it is cut off the sperm cannot get to the egg and the Egg cannot get to the sperm we used to just cut them in half and tie off the ends or burn the ends or whatever was done during the surgical procedure nowadays we more often actually remove the tube so this is a picture um looking into the from the abdomen into the top of the pelvis this is the top of the uterus and this is one tube that's still there and this is another tube removed the reason we now do it this way more often is because we've we've seen that removing the Fallopian tubes actually reduces your risk of ovarian cancer all right moving on to Progesterone only and I do apologize if I'm talking very fast I just still have a lot of info to cover um all right so progesterone only overall what does it do um it lessens bleeding um and it works for birth control and it's almost it's safer almost everyone there's very few contraindications for anyone have to have progesterone um so there's two types of progesterone pills so we'll start with that one is called the mini pill um this actually is not the mini pill so don't read this right here but I just wanted to show a picture where all the pills are the same color all four weeks of it because it's meant to be like a monthly um pack um all four weeks that are the same color they all have a dose of norepindrome in it like kind of a low-dose progesterone daily progesterone it is very important to take it at the same time every day um and mo this is most often used during like lactation like when someone's nursing and they know that it's just going to be for a short time in their lives and they're not 100 sure what you know other birth control they want and they just kind of want something to hold them over it can be used as someone's regular birth control but because the timing is so important of like within a three hour window every day um it's some little bit high maintenance um so it's um but it's definitely an option then there's something called slend which is a newer progesterone only birth control it's a different type of progesterone and it was kind of it's kind of I call it like a hybrid between a progesterone only and a combined and it is progesterone only there's

no estrogen in here um but it does give these last four pills it does give a placebo week and one is a placebo week or or days is it gives your body a chance to withdraw from the hormone exposure and get a bleed so what this pill does is it allows you to have a scheduled bleed and this is helpful for people who may have irregular bleeding and random spotting that's very frustrating um on the standard mini pail that does not have atypical um Placebo withdrawal time it is still effective for contraception even though you're taking that break so that's why it's kind of like a little bit of a cross between the two and there's less of that strict three hour window it's more like a full day if you forget a pill you have a day to catch up all right the cut the um leave an adjustable iuds so these are kind of we're comparing it almost to the Copper iuds um all um four iuds available and the United States have the same hormone in it as progesterone leaving a gestural um Marina and Lolita are the higher or it's a regular adult ones they're just different manufacturers they're honestly all the same stuff same hormone same dose um and they last for eight years for contraception and they are FDA approved for five years of treatment for heavy bleeding so why are they also a treatment on top of being a birth control because the main side effect of a copper I uh sorry of a progesterone IUD or anything progesterone is thinning the lining of the uterus when we thin the lining of the uterus over time the periods themselves either become non-existent for some people or much lighter or shorter and so that's why the higher dose one is used as a treatment for that kyleena is a little bit smaller it's this little green one over here is a little bit smaller and it has a lower dose so it only lasts for five years um it is just as effective for birth control but because the dose is lower it's just it doesn't do as good of a job of like potentially taking periods away but it does again lighten it and Skyla again still a tiny drop smaller a Teensy tiny dose lower I'd still call kyleena and Skyla lovedos and that one lasts for three years um main side effect of these sometimes you can get some irregular or prolonged bleeding or spotting as it's first put in um usually it takes a few weeks to a few months to adjust to it um timing is super important this is like a big thing of mine um I like to get it put in closer to the time that someone's finished a period as opposed to the time that they're gonna gonna write about to get their period so that will usually minimize the amount of um bleeding next one on is the next one this is like a little toothpick size rod that's full of progesterone each and a gestural and it's injected under local anesthesia we just put a little numbing medicine in inject it in you don't see it but you can feel it right on your under like middle inner arm um and um there can be some spotting on it as well but overall it usually lightens periods and this lasts for three years um and then we will um whoops sorry than just getting to the devil prefer injection which is not my favorite I'm gonna add my bias here not my favorite um but it's a ever as a progesterone injection every three months it's really one of the only birth controls that we see some weight gain on I'd say about 10 to 20 pounds for about half the people who are on it there's also a slower return to fertility I mean some people can get pregnant you know when if they don't get their next dose but sometimes it can take up to like almost a year and a half before your fertility really returns so it's a little harder to control if you want to plan your pregnancies a little bit more um and if someone's on it for you know over five years sometimes we'll actually see some bone loss from it too so it may not be the best idea for someone who is closer to menopause than others where we see that anyways and then I'm going to add this in two even though it's not a kind of like a daily thing that you would use but emergency contraception and what that is is if you have had sex during a time that you don't feel like you've had adequate contraception you think you're pretty close to your ovulation or fertile window um what you can do is as soon as possible up like from that episode of sex up until 72 hours you can take what's called Plan B um and that is just kind of like a high dose pill of the sleeve and a gestural that delays ovulation it does not cause a pregnancy to end if that was already started but it does delay ovulation so that the egg and the sperm don't meet um you this you can get it

actually not over the counter but behind the counter which means you have to go to the pharmacist and ask for it um kind of like um like a Sudafed or something like that that you just have to ask for but you don't need a doctor's prescription um it also comes in generic so there's these are two of them I can get at Walmart or Target um so becoming very very accessible especially with the climate that is going on in this country um and then there is also a different type of progesterone that does pretty much the same thing but this Ella that is prescription um and then I have a little picture of the copper IUD up here too um and that's because copper iuds can also be put in and used as long-term or as emergency contraception but then hey you already have your long-term contraception as well so it's kind of like um it takes care of um two issues so if you're finding that you're using emerging contraception a lot you'll probably want to think about finding a better method or a method at all um that will make it so you don't have to feel stressed and use the emergency one all the time all right and then very quickly in my last like five minutes um we're going to go over all the combination hormonal birth control options so um combination means that there's two an estrogen and progesterone and basically the way it's working is by taking the Same by being exposed to the same dose of these hormones every day um it overrides your normal cycling that's happening in your menstrual cycle so it prevents ovulation um because it's those up and down throughout the month that causes ovulation to happen so if you don't ovulate and you don't release that egg you're not going to get pregnant um and what we can also do with these a little easier than some of the other ones is we can actually like control your periods or I'd say you're bleed a little bit more um we know when it's coming based on what you're on and we can kind of move it around so it gives that predictability and manipulation ability so I'm sure everyone's heard of the pill that's what's when people say the pill that's really what it's referred to but there's so so many times types there's not just one pill and they usually vary by dose of estrogen and progesterone and the types of progesterone there are so so many so if you don't like something it doesn't mean you don't like the pill it just means you don't like that pill um and you have to take it every day um you it usually has a nice side effect of making periods lighter less crampy um and sometimes even shorter um and it's kind of meant to mimic the way that they give it to you is like a month on a monthly basis that kind of mimics a natural cycle just because that's what people are used to but you definitely don't have to take it that way you can take it also what's called in continuous form where you don't take those Placebo weeks if you look here this is these white pills that's the hormone pills for three weeks and then a week off those are the empty or Placebo or sugar pills that don't have anything in them so what your body does when you don't aren't exposed to that hormone anymore it withdraws and you bleed um you definitely don't have to take these and just go into your next pack and that's how we move periods around okay and then if you find that you kind of like this kind of like way of cycle predictability and you like how um it's working for birth control but it's just really hard for you to take a pill every day there are some other options that make this easier um and um one of these ways is vaginal rings of which there are two um the NuvaRing and aloe vera the NuvaRing is a um a I say generally low dose option there's only one dose of it um and use it's a super like soft almost like a little like jelly bracelet that we used to wear when we were kids and you smush it down you put it in the vagina and it stays in there for three weeks just like three weeks of the pill you take it out for a week and that's the way you get your period um it should not be uncomfortable during sex um if it is you can take it out for a few hours at a time you just have to remember to put it back in the m and the nuva ring is every month you use a different ring andovera is a newer ring you can see it's a little bit thicker it's actually not much bigger it's just thicker um that is one ring you use for the whole year it actually lasts for 13 Cycles which equals 12 months of the calendar year and um in for three weeks out for a week foreign and then the other um the last

option for contraception a combined hormonal contraception are the patches zooline and twirla are the ones now on the market um and you have to change them weekly um there is a weight limit for it um just due to the absorption um Through Your Skin of the of the hormones um but there and then one of the side effects you can get a little bit of irritation by the adhesive that that's a little different from other ones but that is um these are weekly patches where the first three weeks of it have hormones and the last week you don't wear a patch because that's the week it withdraw all right very quickly we're going over some side effects so for hormonal birth control which includes progesterone and combined you can get spotting and staining um sometimes the lower the dose you get on it the more likely you will have those um bleeding irregularities um so sometimes we'll just increase the dose a little bit and it then the spotting will go away or we switch the progesterone up because maybe you do better with a different one um other side effects include mood changes headaches acne flare decreased libido vaginal dryness and bloating but some people have these on their normal cycle and birth control actually really helps them um so again that's why I have this last point where not all pills are the same and not all people have the same some people love on birth control and enough their friend hates it or the or vice versa so if you're having any of these specifically right when you started a pill or or a method at all you know think definitely think about that as a reason but remember and sometimes they also help these um Can these situations as well and when choosing a birth control I think one of the most important things to think about is what is my priority like why do I want to be in birth control to begin with is do I have like crazy heavy periods and I need something to kind of help with it um do I is Effectiveness percentage of the method important like is it okay if like hey I'm not planning a pregnancy but if it happened that's fine or I cannot get pregnant at all right so where are you kind of in that and that kind of helps um move through decision making um and then how important is it for you to be able to control your cycle some people really hate their periods some people don't mind it at all like so where are you at with that and that I can also dictate kind of what you end up choosing and then so as take home points it's really this is an individual decision just because your friend or sister or mother are you know cashier at Target uses one method doesn't mean that's for you um really think about what you want um and again it takes sometimes a lot of trial and error right there's a lot of methods so sometimes we just have to like put our time in a couple months you know for each method that we're trying and see you know really give it a good chance and if it doesn't work for you then we move on but there are so many options out there we can always find one okay and that's it all right we're gonna hand it off to Beth now all right thank you so much Dr Helman I know that was a great deal of information um so much presented in a very short amount of time so I really appreciate it there were a ton of questions in the question and answer box and Dr Denise Moses was able to kind of handle it as you were going but again we will be answering some questions live um after Dr Schmidt gives her part of the speech um the talk sorry so I'm going to be introducing Dr Schmidt now um Dr Elizabeth Schmidt is the chief of Family Planning and the Ryan program director in the department of Obstetrics and Gynecology at northwell she is an assistant professor at the Donald and Barbara Zucker school of medicine at Hofstra slash northwell she attended Case Western Reserve University where she graduated magna [__] laude with a double major in chemistry and sociology she then attended the University of Rochester for medical school she went to North Shore University Hospital for residency and Obstetrics and Gynecology and then completed a fellowship in really planning at the Washington University in St Louis where she obtains a masters of clinical science and investigation as well she then returned to northwell where she started now graduated Ryan program and Family Planning she's a reviewer for several journals including Obstetrics and Gynecology contraception is a member of the New York obstetric society and a faculty advisor for

the Hofstra medical students for Choice chapter she has published book chapters and articles on contraception and abortion and lobbies at the state and National level for Reproductive Rights so without further Ado Dr Elizabeth Schmidt thank you hi it's a pleasure to talk with everyone tonight am I sharing my screen are you guys seeing it we are not yet seeing it okay hold on a second no problem all right are you saying it now yes we are wonderful okay perfect thank you thank you for that wonderful introduction I have uh just one disclosure I'm an ad hoc consultant for Cooper Surgical so tonight I just wanted to take a quick review through a couple topics I wanted to talk about pregnancy and childbirth in the United States and I really wanted to talk about the safety of abortion um versus childbirth I want to talk about medical abortion which is the same process that we use to manage miscarriage as well and then I wanted to talk about procedural abortion which is DNC and DNE so let's take a step back and talk about where the United States stands in regards to the rest of the world the U.S actually has the highest rate of women dying from pregnancy and childbirth in comparison to the rest of the world the other issue is that our maternal mortality rates are continuing to increase in comparison with the rest of the industrialized world what's different also is that if you are a minority or person of color those rates are about two to three times higher than if you're um non-minority person also if you're of lower socioeconomic status those rates are also higher so this is just a graph we're really doing a very bad job at protecting um pregnancy capable individuals and as you can see toward the right people of color are disproportionately affected so in comparison to the United Kingdom and Germany um really comparable countries we're doing a really terrible job protecting birthing people um I think graphics do a really good job illustrating this point I think something that we don't really conceptualize is that pregnancy carries significant risk um and we kind of just think oh you know I'll get pregnant not even really we don't even think about it but um as someone who provides abortion care I get called not infrequently on an emergency basis to terminate pregnancies for people in the hospital because it is a life-threatening situation so it's just something to keep in the back of your mind as we talk about this something else to think about is pregnancy is often unintended um about half of all pregnancies in the United States are unplanned um and I'm on Long Island and I'm I live in Queens and so we're very close to New York City it's actually about 60 percent of pregnancies in Manhattan and New York City are unintended so these um numbers will vary depending on what part of the country you're in so what happens to these unintended pregnancies it really varies again depending on where you're at in the country but unintended pregnancy is very common um and also abortion is extremely common about one in Four Women by the age of 40 will terminate a pregnancy so just so that we're all on the same page if you've heard the term D and C dilation and curettage this is the procedure to remove pregnancy tissue from the uterus this is a very common procedure it's the same procedure we use to terminate a live pregnancy or to remove um if you've had a miscarriage to remove tissue if you've had a miscarriage it's also used if you're having a miscarriage in process or it's called an incomplete abortion we use a lot of these terms kind of um uh you know interchangeably so it can be a little confusing but it's the same procedure DNE is a dilation and evacuation that's what we do after 14 weeks of pregnancy and that's done for the same reasons if you have a pregnancy loss it's the same procedure we do for an induced abortion and again you notice in the South and the southern states unintended pregnancy rates are higher these states also have higher rates of Women and Infants dying from pregnancy related complications again um a quarter of pregnancy capable individuals will have a pregnancy termination in stark contrast abortion is incredibly safe the risk of dying from a first trimester termination is about one out of a million that can also be extrapolated to if you need a DNC for a miscarriage it is extraordinarily safe the risk of dying from a DNC if you need it for a miscarriage is similar to that of dying from a dental

procedure that basically is almost impossible so it's very safe to have a DNC but the risk of dying from a full-term pregnancy is actually much higher now that roe has been reversed it has been posited that the risk of dying from pregnancy is actually going to increase and again if you're a person of color that risk is going to be higher and it has been shown that states with more abortion restrictions particularly in the South and the Midwest are going to have higher rates of women dying from pregnancy and complications of delivery if we go back to 1972 1973 after row passed women stopped dying from complications of pregnancy again I just I like pictures and I like data the risk of dying from a first trimester abortion is about one in a million but the risk of dying from Viagra is much higher but we have no legislation regarding this drug which actually is much more dangerous when you look at these risks in total and that really comes down to a it just comes down to sexism quite frankly um but I want to keep this in mind that we'll loop back to it when we're talking about medical abortion because there was a recent court case that um wanted to outline with a pristine which we use for a lot of things in women's health when we look at laws restricting abortion this disproportionately affects certain patient populations the majority of abortions occur in poor and low income women so this will disproportionately affect um people who really need help um and it also will worsen economic outcomes for these folks so what happens when someone isn't able to get the care that they think that they need so the idea for a very large research study came from a 2007 Supreme Court case when Justice Anthony Anthony Kennedy speculated that abortions will lead to poorer mental health outcomes and he stated that severe depression and loss of self-esteem would naturally occur after someone has an abortion and we actually have a lot of data already showing that that isn't the case but there was a researcher out of UCSF who said you know let me study this so they have a massive study that showed what actually happens to people who are able to obtain care and those who are not able to obtain their abortions so they looked at over a thousand patients across the United States who were able to obtain care and who weren't able to obtain care they publish over 50 peer-reviewed papers and they've also published a book what they found um was very telling women who were denied an abortion were four times more likely to live below the federal poverty level and they were also more likely to have serious pregnancy complications including eclampsia which is seizures and death these people were also more likely to stay with abusive partners and have anxiety and loss of self-esteem in the short term again they were more likely to live in poverty be unemployed and more likely to need government benefits sadly they were more likely to be raising a child with an abusive partner than someone who was able to have an abortion this also affected the financial well-being and development of their children's Children's Mental development as well I think something's very telling we talked about the safety of abortion two women died who were not able to access an abortion no women died in the study who were able to access a termination so let's switch gears I wanted to talk about the methods of terminating a pregnancy which again are the same methods that we use to manage miscarriage or pregnancy loss so in the first trimester that's the first three months of pregnancy up to 14 weeks we can take pills which is called medical management and we typically use that up to um 11 12 weeks or we can do a procedure which is called the dilation and curettage in the second trimester which is above 14 weeks we can still do a procedure which is called a dilation and evacuation we'll typically do the procedures up to about 26 weeks also above 14 weeks we can do what's called an induction where you go to labor and delivery and we give you medicines and you would deliver vaginally for certain people they may need to have a c-section incision or for certain indications people may also end up with a hysterectomy it all depends on kind of what what the clinical situation is so the most common regimens for medication abortion in the United States are what's recently been in the news mifepristone and mesoprostol so this is the fastest

and the most effective regimen and there was a recent court case where um a judge out of Texas deemed that the FDA approval process was too fast and the FDA did not use an appropriate process to approve mifa Personnel more than 20 years ago and myself and some colleagues wrote a paper last year expanding on the safety and efficacy of mepheprostone and there have been over 400 randomized controlled trials looking at this and it is an extremely safe medication it's safer than Tylenol alternatively you can use Methotrexate which is a medicine we use for topic pregnancies you can also just use mesoprostol which is a medicine we use on labor and delivery to induce labor so these medicines are all very safe but the most effective regimen is mifipristone which we also use for the second trimester procedures we also use it for induction of labor for fetal demises so we use all of these medications all the time and it's critical that we have access to mephopristone during the Texas case everyone in my community and OB gyns we were very very worried because we used methopristone for miscarriage management every day so again medication abortion is extremely common we've really seen an uptick in the use of medical management because people like to have the option of managing their miscarriages at home also managing their unplanned pregnancies at home and in more than half of unplanned pregnancies now are managed medically this is also the new face of illegal abortion in states where abortion has become illegal people are are now Outsourcing pills online or they're going to Mexico or Canada and getting these medications so I really focused on the safety of abortion at the beginning of the talk but the data are com are very clear and we have over 20 years of data on this the actual risk of dying from medical abortion is nearly negligible it's .0035 percent and I I alluded to the number of clinical trials um it's it's really astounding the risk of a medical abortion is similar to that of antibiotics or ibuprofen or Tylenol these medications are extremely safe and if you want to take these medications for miscarriage management you can really be assured you are in you know you're very safe when taking these medications and almost every other day I am using these medications for miscarriage management for my patients um so again just going back we were very worried with the Texas case because using Memphis is much more effective than just using mesoprostol alone so this is why we don't want politicians interfering with the practice of medicine because if a person is so important for all of our patients not just abortion care so going back to the risks again abortion is very safe why don't we have any laws regarding the risk of Viagra Viagra is 15 times more dangerous than mifoprestone it comes down to sexism and people wanting to control our medical decisions somifristone blocks progesterone in the body and then mesoprostol makes the uterus contract and expel the pregnancy and it's the same with the miscarriage that's how it works the vast majority of abortions are performed in the first trimester most are performed before nine weeks very few procedures are performed above 20 weeks this goes this still applies for procedures that I do for fetal demises very few fetal demises occur after 20 weeks but they do occur and so I use these same medications for dnes so how do we decide medication versus a DNC procedure this is how I counsel my patients honestly I give them I I'll go through both options do you want medical management do you want surgical management um I can do the vacuum the DNC in my office um and it is very quick we can give oral pain medication we also do local anesthesia and this is the DNC we put a small and we we give local anesthesia we insert a little suction curette it can be done very early we can do it in the office we can do it in a procedure room or we can go to the operating room and you go completely to sleep and this is exactly what it looks like um you can see it we use sterile instruments and we use a little suction cure it looks like a little plastic straw this is a suction machine on the left when we're in the operating room and then we also use little handheld vacuums when we're in the office it doesn't make any noise in the office it takes about five minutes it's very easy and very safe to do in the office in terms of anesthesia when we're in the office we

do use local anesthesia that means you're not asleep we also can give you anti-anxiety medicine in the office for pregnancies further along for either fetal demise if you have a miscarriage or if we are terminating a pregnancy we typically do go to the operating room and you are asleep that picture on the right is how we inject the medicine in the cervix regarding the safety of abortion this is the same for if you have a pregnancy loss or if you are terminating a pregnancy for either fetal anomalies or for unplanned pregnancy there are no risks for infertility in the future you will be able to get pregnant which is why I always talk about birth control which we can place at the time of the procedure there's no risk for a topic miscarriages birth defects or preterm delivery there's no association with abortion and breast cancer all well-designed trials have shown no association and there is no association with your mental health care abortion is extraordinarily safe well-designed Studies have shown again and again major complications are less than one percent with medical and surgical abortion abortion again does not pose a psychological Hazard for women well-designed Studies have shown this and again when we look back to the turn away study that again cross National studies showed Through The Years there are no um psychological risks in fact most people describe feeling relieved after their terminations what people have actually found again across multiple types of studies across International Studies people who are forced to carry unintended pregnancies to term actually are at risk for mental health problems regarding second trimester procedures it's the same procedure for termination as for a miscarriage we can have labor induction we can do the surgical procedure the DNE we can do the c-section incision or we can actually take out the uterus DNA is the safest it is the most cost effective and efficient and it's the most common method in the United States this is about 11 percent of abortions in the U.S why do people have second trimester procedures often it's for fatal anomalies in my practice it is but for people sometimes they didn't know they were pregnant if it's for fetal anomalies oftentimes they've been getting a workup but sometimes fetal anomalies are not detected until the 20-week anatomy scan that's a large part of our practice or people get sick in pregnancy so that's why I'm getting called to the hospital in the middle of the night and doing emergency procedures and again that's why we need Memphis to be safe and available in this country um 1.3 percent of abortions happen above 20 weeks again for things that I mentioned and again that's why the abortion Bans are very dangerous because if we're limiting abortions to only say 12 weeks what's going to happen to people who need abortions Beyond 12 weeks where are they going to go how are they going to get care it's dangerous to women and I'm very very worried about women's safety dnes are considered a two-day procedure the first day we place dilators and we also give them if a person um and then the second day we go to the operating room and we take out the dilators and we remove the pregnancy and this is what the dilators actually look like over time they gently swell to help dilate the cervix after a DNC and after a DNE it is normal to bleed for one to two to three weeks if you soak through more than a pad an hour you need to call your fertility returns as soon as the procedure is done genetic testing can take one to two months if you have more than one pregnancy loss we do recommend a workup your milk can come in but we do have medications that can prevent that so all in all pregnancy actually is dangerous um and those risks can be higher for certain groups induced abortion is extremely common about one out of four women will need an abortion in the in the United States most people can be offered either procedural or a medical abortion and both options are very safe but remember DNC and DNA it's the same procedure if you have a miscarriage or an induced termination overall complications are very low for both procedures abortion is very safe and it is always safer than continuing our pregnancy and happy to take any questions all right thank you um Dr Schmidt so much for that talk again it was an incredible amount of information but very very necessary there was a question in the chat specifically asking about um

understanding the Halal ramifications for um abortion and just before we open up the question and answer I just want to again um reiterate that this is a medical talk provided to really understand and work with the community with the goal of providing basic and educational information a lot of these decisions are personal and require personal and personal rabbinic understanding understanding um Angela itself is not a halach or a poskinying body so that really isn't the scope of the talk tonight but it's really just important to understand the options that are available to us um with that I just want to again thank Dr Schmidt thank Dr Hellman for providing or really being here and taking the time out of their evenings with their kids and their families and whatever else is going on in their lives to give this information and really be here to answer a few questions um there are a good amount of questions in the chat but there is one that I will start with um is what forms of contraception can be used for those diagnosed with breast cancer and I guess we can start with Dr Hellman and if um Dr Schmidt if you have anything else to add please feel free and if you can just stop sharing your screen just so that it's no longer on the page that would be wonderful thank you um all right so the um what can be used for people with breast cancer so I think it's um pretty important to know what type of breast cancer we're talking about there are some that are have receptors to hormones on them but the estrogen and progesterone receptor positive type of tumors and there are some that don't um it's really the only tumors that have um um are hormonally mediated meaning that that was a factor that we may want to stay away from whatever type of hormone receptor it has but overall we have not really seen any studies showing that breast cancer increases the risk of oh sorry that hormonal birth control increases the risk of breast cancer so if someone has had a non-hormonally mediated tumor really still everything is is an option okay um I think Dr Schmidt accidentally fell off the line and that's okay hopefully she'll be able to return but for now I will be um gearing most of the questions towards you if that's all right sounds good okay um so the next question is um how do I talk to my parents about starting birth control recovery periods and painting periods I brought up before and all they say is you're not having sex so you don't need it and I think this is a big question that a lot of teenagers or young adults may have um Denise um Dr Moses mentioned in um in answering this question that may be bringing a parent um to your appointment with your gynecologist would be helpful but we were wondering if you have any other suggestions yeah I mean look obviously this question points to the fact that this can be very charged especially in specific communities religious ones being being some of those um and yeah I think we have to remember that I mean we call it birth control we call it contraception because that's kind of what it was it was made for but what we see is there is side effects that are great to help with medical conditions organicologic conditions so these really shouldn't be thought of as only contraceptives or birth control they really are a medication like you would treat high blood pressure with or your thyroid issue with like they're just in a specific class that of of hormonal medications that can help many gynecologic conditions um and um you know definitely I think it was a wonderful suggestion by Dr Moses to bring that parent along so that they kind of understand that and just because someone is on birth control and they're not sexually active doesn't mean that automatically they will become that um so um you know and on the flip side I'm just going to bring this up on the flip side if you do need contraception because you're having intercourse and you don't want to be pregnant and you're finding resistance you can also work with your doctor and be like hey I also need it for my periods like even though that may not be a hundred percent truthful to the rest of the world and like you and your doctor know that like kind of the real reason um but if you really need birth control like that's kind of one way to make it okay for the rest of the of the community as well so you should do what's what's right for you and what you need I know I like the idea of reframing exact perception is I think that's a really helpful

way of kind of going about it um the next question Dr Schmidt are you um on the line everything's okay with your agenda sorry okay good um the next question is more so geared towards you um so the question is what follow-up care is needed after a successful medical termination uh well it varies you have the option of doing an office visit at one or two weeks so we can do an ultrasound and place an IUD at that time or an implant or start any birth control or you can do a Telehealth at one week and then you take a pregnancy test um in three weeks after that okay all right so it does endothering but um some people but that's gender the general gist of it yeah I mean with covid we've also been doing you know altered follow-ups you can also do just a blood work great um and then there was a couple of questions about um like late term um termination specifically talking about dnes there was a question um that came in what can cause placental retention resulting in the need for DNE um I'm not sure placenta do you mean like after a delivery yeah I yeah I think like an adherent placenta is what um is being passed like is there anything that causes it increase your risk of popping that and then what the management of that may be well uh uh DNA is you know removing uh pregnancy in the second trimester so uh retained placenta can occur after any pregnancy at any trimester so oftentimes you know I'll get called in just because of my skill set to help with retain placenta at any time so that's why it's important for residents and medical students to get trained in abortion care because we often will need this skill set okay great um the next question is more Soviets towards Dr Hallman and I think there were a couple of questions um regarding like Logistics with the diaphragm if you can shed some light specifically about fitting of the diaphragm and um there were a couple of questions asking about clarification whether it's a barrier whether it's a vessel to hold the spermicide or gel so um it's not like you squeeze the gel inside of it um it's more like you put it around the edge and that's because um so use the diaphragms that are more available now as that kind of one size fits most and remember not everyone has the same size vagina so um it's it's kind of a hybrid between barrier and also needing that spermicide too so that's why um at least how logically sometimes it's a bit more permissible that I will leave to ask your own local Orthodox Rabbi um but um it's not just a vessel for the spermicide you put the spermicide around it so that if there is a little Gap in the covering of the cervix that there's that like extra layer of protection um that will like prevent the sperm from getting in because it kills it um yeah and then and then getting it fitted um your gynecologist kind of like just takes you know a feel for if it's really kind of suctioned into the top and covering the cervix okay great um and do you find that um I mean from your experience or either of your experiences that people are um comfortable with fitting diagrams because there are also again a couple of questions saying they don't know how to get fit I mean I think I think people um who are very motivated to use it as their method are very comfortable with it um but again it's it's kind of like it's somewhat similar to a menstrual cup so if you use that like for your um for your period um hygiene then um you know it's kind of like a similar type of insertion and removal um you just have to feel comfortable like putting something in you know high up in you and and removing it um it can be a touch messy but um if you're cool with that then then great I like I have samples in my office and so what I really like to do is I give someone the sample and I have them put it in and take it out with me there um to help them with it so and I found that really helps allay anyone's fears so they feel like they're doing it right if they have questions ask immediately and I've also done stuff like that with like a NuvaRing or like the imaginal Rings where people are like sounds really cool but like can you just like make sure that I'm like doing it right and so they'll get it from the pharmacy bring it in and like show me what they're doing so and then they feel a lot better about it yeah a little bit more confident with that exactly okay um and then a question I think that both of you can answer um but are DNC is used for any other reasons outside of pregnancy and abortion care yeah uh Dr Schmidt what are

some other um indications for that so it's an extremely common procedure um we use it throughout the lifespan we use it to examine for abnormal bleeding we use it if we're worried about cancer um young and old I mean really it's a very common procedure so yes the answer is yes okay okay um and Dr Hillman anything to add on yeah I mean it's basically a way to remove something in the uterus that you don't want there or you need to biopsy um and so that's like it pertains to pregnancies um either pregnancy loss tissue or an undesired pregnancy and a polyp or you know overgrown uterine lining um so yeah it's really just a way to remove tissue okay um next couple of questions so I'm just reading a couple of them so I'm Dr Schmidt can you talk a little bit about management of um possibly retained products of conception after a medical termination and what the options are what the process may be and like the timeline of those types of things sure um it totally depends I mean oftentimes with time the tissue will pass in America people don't really like to wait so we usually offer repeat doses of mesoprostol if that doesn't work we can do it in office DNC the the manual vacuum respiration or we can go to the operating room and do the DNC as well so those are really the kind of the options wait and see repeat doses of mesoprostol in Office DNC or operating room DNC and it really just depends on what the clinical situation is and what you want to do okay great um and then there is a question asking about a good method for a short-term birth control after a miscarriage or a DNC that is safe to start trying right before you want to get pregnant again so kind of a short interval is there anything that you generally suggest to your patients and Dr Schmidt or Dr Kellman um for my religious patients yeah for my Orthodox patients typically my Orthodox patients will go back on a pill I'll be honest um because that's usually the easiest for them yeah and I I find the same thing I think that but really really anything is an option outside of like the long-acting reversible contraception like an IUD or nexplanon or something that needs to be inserted so anything that you're using on a daily or a monthly basis is easy to use on a daily or a monthly basis and you can control it's very you don't have to like go get it removed like you are in control of how long you want to be on that for and make a decision month by month if this is something that you want to continue or are you ready to try again or are you ready to move on to something longer acting but that being said I have had you know patients who are like can I have my copper IUD for a couple months yeah you can yeah it's fine you can do whatever you can use whatever you want if you're happy exactly okay um all right yeah I think that's really helpful and then how long do you have to wait um before getting pregnant after an abortion or a miscarriage that's a great question the data are very clear after a first trimester miscarriage or termination you can get pregnant right away it is totally safe the data are more mixed after a second trimester loss or termination and depending on what study you look at I mean the who recommend like 18 months after a second trimester loss and I mean that's no one's going to wait a year and a half I mean that's just ridiculous so my recommendations to my patients are really like you know physically and emotionally when you're ready you can you can try for most of my patients I recommend at least waiting for until you get your period because a lot of my patients are fetal anomaly patients and um it's helpful for looking for fetal anomalies like to know when your last period was because we're looking at ultrasounds we're doing a lot of testing but it's not the end of the world if you don't have a period but again this is my population and that's a little bit of a bias there um but for a lot of folks it is going to be you know a couple months that they want to wait but the data are very mixed when it comes to second trimester losses or terminations so that there is a copy out there right yeah because someone as you were speaking asked ask asked a specific question about those 18 months if it technically is the recommendation why do you kind of not really hold by it but it seems that it's because the research is so mixed oh yeah and it depends because I mean if you're looking at the Danish pregnancy registry that's a very homogeneous

population and America is not Denmark I mean we're not all six foot one 120 pounds I mean that's not America so I don't really think that's applicable to us and so when you do a literature search I mean the data are America just isn't like that so I think you also have to take it with a you know a pound of salt I mean like we just also if I've got a 40 year old you know who wants to get pregnant right away she's not going to wait until she's 43 and she won't be able to get pregnant so I think you really have to look at it with what your situation is you know individualize it versus just taking the recommendation 100 exactly mm-hmm and also you know this is not medical advice this is like my general kind of Gestalt um and you also have to talk with your own OB GYN and if you have a Maternal Fetal Medicine doctor that you're working with you also have discuss it with them but this is in general kind of my practice I'm sure um and then I've been kind of Switching gears more towards the contraceptive aspect of our talk um but there were a couple of questions about um either going from like one IUD straight to another so without having to Break um in the same idea with oral contraceptives kind of not using the placebo week and just continuing on um are there any issues with going from one IUD to another without a break or not taking the placebo week when you're using um the combined oral contraceptives I think Dr Hellman and then if Dr Schmidt you have anything to matter yeah so for the iuds it's ideal to take it out and put another one in right away then you literally have like no um there's you have no break in your contraception as far as like the effectiveness so that that's great to do you totally can do that some people um will do that when they are done having kids and they um they know hey I'm I'm 35 I had my last kid I'm done I'm good and then they're still their potential for pregnancy could be for another 15 years um and so they have repetitive iuds that are put in to get them through menopause and that's totally fine um as far as the pill goes um there's really no rule there's no three-month rule um there's three months of custom but it's not a rule of yes you can take um continuous birth control pills without taking the placebo week um as long as you want as long as you can I personally would recommend to my patients that if you start spotting if you start bleeding if it becomes heavier over a couple of days that's your sign like your lining started breaking down that's your sign it is time to give yourself that break that could come after five weeks that could come in five months that could come in five years um and so it's it's um we can kind of individualize it but there's nothing wrong with taking it continuously um the reason the three-month like rule came about um that where that gets recommended is to kind of help avoid that unpredictable bleeding or spotting and still not have a monthly scheduled bleed but have an every three month schedule bleed um so it's just another schedule that kind of became law but it's not at all if there's anything to add on that one I agree um the only reason as long as you're on progesterone you don't have to have any kind of bleed so if you have I mean some kind of spotting just stop for you know three to five days and then restart and it's usually better recommend so great and then my last question to you and then we will log off and let everyone enjoy their evenings but what age should you or can you stop taking birth control and what are the dangers of taking it past stage so I contracept people up to the age of 55. um because uh for various reasons um I mean but you know everyone's different in terms of you know where they're at when their mother went through menopause um you can also do blood work and if depending on what your levels are you may want to you know discuss with your own OB GYN but that's my my practice yeah and I would agree I definitely do somewhere in the early 50s again taking the patient's history and I think that um it's also you know you at one point we have to also factor in if any other medical conditions have developed that would make whatever method you're on you know not really indicated or do we have to switch to something else but um I mean anyone who is still fertile whether that fertility is good or not good based on your age um deserves contraception so there definitely are safe options for anyone at any age until heading

menopause and when you don't need it anymore I think it's amazing um I think we are going to wrap up thank you again both of you really for providing such like a breath of knowledge um in a really like wonderful and I think clear way um so again Dr Hellman Dr Schmidt thank you so much um thank you to the JOWMA women's health committee for kind of helping organize and run everything behind the scenes and Jonah and of course all of you for attending um look out for more JOWMA webinars and thank you so much have a wonderful night