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Continuation of the Etonogestrel Implant in Women Undergoing Immediate Postabortion Placement

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Abstract

Objective—To estimate whether women who receive an immediate postabortion etonogestrel subdermal implant have higher discontinuation rates than women who undergo an interval insertion (insertion not associated with a recent pregnancy).

Methods—This was a secondary analysis of the Contraceptive CHOICE Project. We compared 12-month continuation rates for the subdermal implant between women undergoing immediate postabortion placement and women who underwent an interval placement. Continuation rates were compared using Kaplan-Meier estimator of survival function and Cox proportional hazard models.

Results—Over the study period, 141 women received the implant immediately postabortion and 935 women underwent an interval placement. The 12-month continuation rates were similar; 81.5% among women undergoing immediate postabortion placement and 82.8% among women undergoing interval placement ($p=0.54$). In the survival analysis, women who received an immediate postabortion implant were no more likely to discontinue their method than women who had an interval placement (adjusted HR 1.04, 95% CI 0.68–1.60). The most common reason given for discontinuation was frequent or irregular bleeding, which was reported by 65.4% of women discontinuing in the immediate postabortion group and 56.7% in the interval group.

Conclusion—Women who undergo immediate postabortion placement of the subdermal implant have high rates of continuation that are equivalent to women undergoing interval insertion. Immediate postabortion LARC should be available to women undergoing induced abortion to decrease the risk of repeat unplanned pregnancy.

1. Introduction

The rates of unintended pregnancy and abortion have not changed significantly over the past few decades and remain a public health challenge. (1, 2) The reasons for the high rate of unintended pregnancy and abortion are multifactorial, but it is clear that contraceptive failure, including incorrect or inconsistent use, is an important factor. (3) While nearly all

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women have used a contraceptive method, not all methods are continued at the same rate or have the same inherent effectiveness. (4–6) Long-acting reversible contraceptive (LARC) methods, including the most effective reversible methods such as the intrauterine device (IUD) and subdermal implant, have the potential to significantly impact the rate of both unintended pregnancy and abortion. (7)

Repeat abortion accounts for 47% of all abortions in the United States;(8) therefore it is important to provide access to LARC methods at the time of abortion in order to reduce this risk. In fact, one recent study demonstrated that women who received immediate postabortion IUDs were 63% less likely to experience a repeat abortion. (9) A recently published prospective cohort study from New Zealand showed that women who initiated depo-medroxyprogesterone acetate (DMPA) or received an IUD immediately postabortion had significantly lower rates of repeat abortion up to two years later (10). We have previously shown that, compared to women without a recent abortion, women offered immediate postabortion LARC were three times more likely to choose IUDs and 50% more likely to choose implants. (11)

Choosing a contraceptive method at the time of abortion may influence continuation in a positive or negative direction. There is some concern among clinicians that women who receive an immediate postabortion etonogestrel implant may have higher discontinuation rates than women who have an interval insertion. We conducted this study to estimate whether women who received an immediate postabortion implant would have equivalent 12-month continuation rates to women who received the implant not in association with a recent pregnancy.

2. Materials and Methods

This study is a secondary analysis of the Contraceptive CHOICE Project. CHOICE is a prospective cohort study designed to promote the use of long-acting reversible contraceptive (LARC) methods remove financial barriers to contraception, and evaluate continuation and satisfaction for reversible methods. (12) The objective of this analysis was to compare the 12-month continuation rates of the subdermal etonogestrel implant between women who had the implant placed immediately after a surgical abortion and women who underwent an interval placement. We defined interval placement as 6 weeks or greater from the time of the last pregnancy. We also evaluated continuation rates in women who had a “delayed” insertion of an implant after an abortion, which was performed within 6 weeks but not on the same day as the abortion. This group included women undergoing both medical and surgical abortion.

Between August 2007 and September 2011, CHOICE enrolled 9256 women. Women were eligible to participate if they were 14–45 years of age, resided in St. Louis City or County, had been sexually active with a male partner in the past 6 months or anticipated sexual activity in the next 6 months, had not had a tubal sterilization or hysterectomy, did not desire pregnancy in the next year, and were interested in starting a new reversible contraceptive method. Potential participants were read a short script about long-acting reversible contraception, which stated that IUDs and implants are the most effective methods. The script was read at the time of screening for study eligibility. Participants also underwent comprehensive contraceptive counseling which emphasized the effectiveness of all reversible contraceptive methods. A participant could choose any FDA-approved reversible method of contraception as long as she was not currently using the method. A healthcare provider at our university research site or one of the community partner clinics would determine if the desired contraceptive method was appropriate for the participant according to evidence-based criteria. At baseline, participants provided written informed consent,

completed a comprehensive survey, and received their desired reversible contraceptive method at no cost. Participants completed follow-up surveys by telephone at 3 and 6 months and every 6 months for the study duration (3 years for the first 5090 participants and 2 years for the remainder of the cohort). We obtained approval from the Washington University in St. Louis School of Medicine Human Research Protection Office prior to recruitment of participants.

We compared demographic, socioeconomic and behavioral characteristics of women who had been enrolled in the study for at least 12-months following implant placement. Comparisons were made using chi-square for categorical variables and ANOVA test for continuous variables between women undergoing immediate postabortion, delayed and interval placement. Twelve-month continuation rates were estimated using Kaplan-Meier estimator of survival function. Participants who were lost to follow-up were censored at the time of the last completed survey. Hazard rate ratios (HRs) and corresponding 95% confidence intervals (CI) were calculated using Cox proportional hazard models. Satisfaction was measured on a 3-point scale (“very satisfied,” “somewhat satisfied,” and “not satisfied”). For this analysis, women who discontinued the implant were considered not satisfied.

We performed univariable and multivariable Cox proportional hazards regression to calculate the hazard ratio for factors associated with discontinuation. We planned to include immediate postabortion insertion in the multivariable model regardless of whether it was significant in the univariable model because this was our *a priori* hypothesis. All covariates that were associated with implant discontinuation in the univariable model (at the 0.05 level) or altered the hazard ratio by 10% or greater were included in the multivariable model. We performed all statistical analyses using STATA 11 (StataCorp, College Station, TX).

3. Results

Between August 2007 and November 2010, there were 7472 women enrolled into the CHOICE Project who had initiated their baseline method by 3-months and been enrolled in the study for at least 12-months. Of these, 1178 women received the subdermal implant; 141 received the implant immediately postabortion, 102 women had a “delayed” placement, and 935 women had an interval placement. There were an additional 37 women in this cohort who underwent immediate postpartum implant placement and were excluded from this analysis as continuation of immediate postpartum implants may differ from immediate postabortion or interval placement.

Table 1 shows the demographic and reproductive characteristics for women who received an immediate postabortion implant, “delayed” implant, and interval placement. The 3 groups were similar across demographic and reproductive characteristics, although women who received the implant immediately postabortion were less likely to be Hispanic, have a college education, and report having health insurance. They were more likely to be single, to have higher parity and report a previous history of abortion (prior to the index abortion). Overall, the 12-month continuation rate for the implant was high at 83.0%.

There were a total of 189 women who discontinued the implant during the first 12 months of use. The rates of continuation at 12 months are shown in Table 2 and were similar for the 3 groups: 81.5% of women who received the implant immediately postabortion were still using the implant at 12 months compared to 82.8 % of women who underwent interval placement and 86.3% of women who underwent “delayed” placement. There was no statistically significant difference between these rates ($p = 0.54$). Satisfaction with the implant was also similar across the 3 groups with 73.2% of immediate postabortion implant

users, 79.1% of women undergoing “delayed” placement, and 78.4% of women undergoing interval insertion reporting being “somewhat” or “very satisfied” with the implant at 12 months ($p=0.70$). There were 87 women (7.4%) who had been lost to follow-up by 12 months. There was no further information about implant use available for these women. Loss to follow-up did not differ by the timing of implant placement ($p=0.46$)

Table 3 shows the univariable and multivariable Cox proportional hazards model for factors associated with discontinuation of the implant. In the univariable analysis, women who received the implant immediately postabortion did not have a higher rate of discontinuation compared to women who underwent an interval placement (HR 1.15; 95%CI 0.76–1.74). Women who had a “delayed” placement were also no more likely to discontinue the implant compared to women who had an interval placement (HR 0.79; 95%CI 0.45–1.40). Of the demographic and reproductive characteristics described in Table 1, only separated, divorced, and widowed marital status, some college education, nulliparity, history of a prior abortion, and history of a sexually transmitted infection were significantly associated with discontinuation of the implant in the univariable model. Women who reported being separated, divorced, or widowed were twice as likely to discontinue their implant (HR 2.15, 95%CI 1.17–2.94). Nulliparous women and women with a history of a prior abortion or sexually transmitted infection were slightly more likely to discontinue the implant (HR 1.60; 95%CI 1.19–2.14, HR 1.39; 95%CI 1.01–1.91, and HR 1.39; 95%CI 1.04–1.86 respectively)

After adjusting for the factors significant in the univariable model, we still did not observe any association between immediate postabortion timing of implant placement and discontinuation (adjusted HR 1.04, 95%CI 0.68–1.60) compared to interval placement. In the adjusted model, separated, divorced, and widowed marital status nulliparity, and history of a prior sexually transmitted infection remained significantly associated with discontinuation.

Table 4 shows the reported reasons for discontinuation of the implant. Women could provide up to 3 reasons. Most women provided a single reason for discontinuation (74.6%). There were 48 (19.6%) women who provided 2 reasons and 11 (5.8%) who provided 3 reasons for discontinuation. The most common reason given for discontinuation was frequent or irregular bleeding. Among discontinuers, 65.4% (17/26) of the immediate postabortion group, 76.7% (10/13) of the “delayed” group, and 56.7% (85/150) of the interval group reported frequent or irregular bleeding as the reason for discontinuation ($p=0.29$). The second most common reason given for discontinuation was weight gain with 19.2% of discontinuers in the immediate postabortion group and 15.3% in the interval group reporting weight gain. The percentage of women discontinuing the implant because they were seeking pregnancy was similar between the immediate postabortion group and the interval group (3.8 versus 4.7%).

4. Discussion

We found that the continuation of the etonogestrel subdermal implant at 12 months does not differ between women undergoing immediate postabortion placement, delayed postabortion placement, and interval placement. In addition, the reasons reported for discontinuation were similar between the 3 groups. Our observed continuation rate of 83.0% overall is similar to the other published 12-month continuation rates of the etonogestrel implant. (13, 14) Few studies have specifically evaluated continuation of the implant after immediate postabortion insertion. Women undergoing immediate postabortion placement may have had less time to consider their contraceptive decision and may be more likely to regret their choice, leading to higher discontinuation rates. Recently, Mark et al. presented findings from a study of 12-month continuation rates of the implant in women who underwent immediate postabortion

insertion compared to women undergoing an interval insertion. The rate of discontinuation was higher among women undergoing immediate postabortion insertion compared to the interval group (31.4% versus 19.2%), although this was not a statistically significant difference due to a small sample size.⁽¹⁵⁾ This discontinuation rate among the immediate postabortion placement group is quite a bit higher than our observed rate of 18.5%. We observed higher continuation rates in all three groups of implant users than have previously been reported in the same cohort among women using shorter-acting reversible contraceptive methods such as oral contraceptive pills, contraceptive vaginal ring, transdermal contraceptive patch and depot medroxyprogesterone acetate with estimated 12-month continuation rates of 55%, 54%, 49%, and 57% respectively. ⁽¹⁶⁾

Strengths of our study include a relatively large sample size with a high rate of follow-up, racial and socioeconomic diversity, and systematic assessment of continuation and satisfaction. However, we recognize the limitations of our study. Our cohort was comprised of women willing to enroll in a contraceptive study from a single geographical area which could limit generalizability. In addition, we did not randomize women to immediate postabortion versus interval insertion. At baseline, these groups did differ in demographic and reproductive characteristics. We performed a multivariable Cox proportional hazard regression to adjust for these baseline differences. There were 141 women who received their implant immediately postabortion and a smaller number who discontinued the method. A post-hoc sample size/power calculation indicates that we have >90% power to detect a 2-fold increased risk of discontinuation with 141 immediate postabortion implant insertions and a 5:1 ratio of exposed to comparison participants. With relatively few discontinuers, we had limited ability to find differences in the reasons for discontinuation based on timing of the implant placement. However, the discontinuation rates of 18.5% in the immediate postabortion group and 17.2% in the interval insertion group appear quite similar and this difference was not statistically significant.

Availability of immediate postabortion contraception, especially LARC methods, varies depending on the abortion provider, upfront costs, and other institutional barriers. ⁽¹⁷⁾ Rates of repeat abortion have previously been shown to be lower in women undergoing immediate postabortion IUD insertion. ⁽⁹⁾ A recent study by Tocce et al found that postpartum adolescents who had an immediate postpartum implant placement had a 12-month continuation rate of 86%. The same study found that postpartum implant users were significantly less likely to have a repeat pregnancy within 12 months compared to women who chose another postpartum contraceptive method (2.9% versus 21.3%). ⁽¹⁸⁾ It is reasonable to extrapolate that a reduction in repeat unintended pregnancy would also be observed for women undergoing immediate postabortion implant placement if continuation rates are high. Our results show that these women have equivalent rates of continuation at 12-months compared to interval insertion, and that continuation is significantly higher than that seen with the shorter-acting reversible methods of contraception. Immediate postabortion LARC should be offered to all women undergoing abortion as a strategy to decrease the high rate of unintended pregnancy and repeat abortions observed in the United States.

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Table 1

Demographic and Reproductive Characteristics of Participants Receiving an Etonogestrel Implant by the Timing of Placement

	Immediate Postabortion (n=141)		Delayed (n=102)		Interval (n=935)		P
Mean age, years (SD)	23.1	5.6	22.5	4.9	22.9	5.9	0.69 [*]
Race	n	%	n	%	n	%	
Black	92	65.2	63	61.8	509	54.4	0.11 [†]
White	39	27.7	32	31.4	333	35.6	
Other	10	7.1	7	6.9	93	9.9	
Hispanic ethnicity							
Yes	4	2.9	3	2.9	82	8.8	<0.01 [‡]
No	137	97.2	99	97.1	853	91.2	
BMI							0.08 [‡]
Lower than 25	67	47.5	46	45.5	347	37.5	
25–30	38	27.0	23	22.8	204	27.6	
Higher than 30	36	25.5	32	31.7	324	35.0	
Marital status							<0.01 [‡]
Single	103	73.0	67	65.7	616	66.0	
Married or living with a partner	26	18.4	27	26.5	282	30.2	
Separated, divorced, or widowed	12	8.5	8	7.8	36	3.9	
Education							0.01 [‡]
High school or less	80	56.7	59	57.8	488	52.2	
Some college	56	39.7	32	31.4	314	33.6	
College or graduate school	5	3.5	11	10.8	132	14.1	
Insurance							<0.01 [‡]
No insurance	72	52.2	55	54.5	354	38.3	
Private	37	26.8	30	29.7	326	35.3	
Medicaid/Medicare	29	21.0	16	15.8	244	26.4	
Low socioeconomic status [§]							0.21 [‡]

	Immediate Postabortion (n=141)		Delayed (n=102)		Interval (n=935)		P
	94	66.7	58	56.9	557	59.6	
Yes							
No	47	33.3	44	43.1	378	40.4	
Nulliparous							0.01 [‡]
Yes	61	43.3	52	51.0	483	51.7	
No	80	56.7	50	49.0	452	48.3	
History of prior abortion #							<0.01 [‡]
Yes	62	44.0	36	35.6	172	18.4	
No	79	56.0	65	64.4	763	18.4	
History of prior STI							
Yes	60	42.9	36	35.3	356	38.1	
No	80	57.1	66	64.7	579	61.9	0.44 [‡]

STI, sexually transmitted infection.

* Analysis of variance.

[‡] Chi square.

[‡] Fischer's exact test.

[§] Low socioeconomic status defined as receipt of public assistance or reported difficulty paying for transportation, housing, medical expenses, or food in past 12 months.

[#] History of an abortion before the index abortion for women in the immediate postabortion group or the abortion within the prior 6-week group

Table 2

Rates of Continuation and Satisfaction at 12 Months by the Timing of Implant Placement

	Immediate Postabortion (n=141)	Delayed (n=102)	Interval (n=935)	<i>P</i>
Continuation	81.5%	86.3%	82.8%	0.54
Satisfaction				
Very Satisfied	48.8%	55.8%	54.8%	0.70
Somewhat Satisfied	24.4%	23.3%	23.6%	
Not Satisfied	26.8%	20.9%	21.6%	

Table 3

Univariable and Multivariable Cox Proportional Hazards Model of Factors Associated With Implant Discontinuation

	Hazard Ratio	95% Confidence Interval		P
Univariate				
Timing of implant placement				
Immediate postabortion insertion	1.15	0.76	1.74	0.51
Delayed insertion	0.79	0.45	1.40	0.42
Interval insertion	Ref	Ref	Ref	Ref
Marital status				
Single	1.35	0.95	1.91	0.09
Married or living with a partner	Ref	Ref	Ref	Ref
Separated, divorced, or widowed	2.15	1.17	2.94	0.01
Education				
High school or less	Ref	Ref	Ref	Ref
Some college	1.45	1.07	1.97	0.02
College or graduate school	1.16	0.74	1.82	0.52
Nulliparous	1.60	1.19	2.14	<0.01
History of prior abortion	1.39	1.01	1.91	0.04
History of prior STI	1.39	1.04	1.86	0.02
Multivariable *				
Immediate postabortion insertion	1.04	0.68	1.60	0.84
Delayed insertion	0.74	0.42	1.31	0.31
Interval insertion	Ref	Ref	Ref	Ref
Marital status				
Single	1.06	0.73	1.53	0.77
Married or living with a partner	Ref	Ref	Ref	Ref
Separated, divorced, or widowed	2.30	1.23	4.30	0.01
Education				
High school or less	Ref	Ref	Ref	Ref
Some college	1.32	0.96	1.80	0.08
College or graduate school	0.93	0.58	1.49	0.75
Nulliparous	1.99	1.43	2.78	<0.01
History of prior abortion	1.38	0.98	1.94	0.07
History of prior STI	1.46	1.08	1.98	0.01

STI, sexually transmitted infection.

* Multivariable model adjusted for marital status, educational level, nulliparity, history of a prior abortion, and history of a prior STI.

Table 4

Reasons Given by Participants for Discontinuation of the Implant by Timing of Implant Placement

	Immediate Postabortion (n=141) [†]	Delayed (n=102) [†]	Interval (n=935) [†]
Number discontinued	26	13	150
	n (%)	n (%)	n (%)
Frequent or irregular bleeding	17 (65.4)	10 (76.7)	85 (56.7)
Weight gain	5 (19.2)	0 (0)	23 (15.3)
Change in mood	4 (15.4)	1 (7.7)	8 (5.3)
Acne	3 (11.5)	1 (7.7)	10 (6.7)
Headache	0 (0)	2 (15.4)	9 (6.0)
Arm pain or swelling	1 (3.8)	2 (15.4)	7 (4.7)
Hair loss	2 (7.7)	0 (0)	3 (2.0)
Abdominal cramping	1 (3.8)	0 (0)	8 (5.3)
Desires pregnancy	1 (3.8)	1 (7.7)	7 (4.7)
Change in libido	1 (3.8)	0 (0)	5 (3.3)
Heavy bleeding	0 (0)	1 (7.7)	0 (0)
Breast pain	0 (0)	0 (0)	2 (1.3)
Amenorrhea	0 (0)	0 (0)	2 (1.3)
Fatigue	1 (3.8)	0 (0)	1 (0.7)
Rash or allergic reaction	0 (0)	0 (0)	1 (0.7)
Nausea	0 (0)	0 (0)	3 (2.0)
Other [*]	0 (0)	0 (0)	13 (8.7)
No information provided	1 (3.8)	0 (0)	4 (2.7)

^{*} Includes jaw swelling, “body rejection”, sinus infection, “want to take break from hormones”, “numbness in arms and legs”, “concern I might get a problem”, and “sweating, diarrhea, and anxiety.”

[†] Total values may be greater than 100%, as participants could provide more than one reason for discontinuing the implant.