Improving the uptake of highly effective contraception by women using teratogenic medications

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On any given day, more than 30% of Australian women aged 20–40 years take at least one medication subsidised by the Pharmaceutical Benefits Scheme (PBS), and about half these women take more than one.[1] Of concern for this age group is that almost one-half of pregnancies in Australia are unplanned,[2] and an unintended pregnancy may only be recognised after the fetus has been exposed to a medication. Consequently, guidelines recommend that highly effective contraceptive measures should be taken by all women of reproductive age during treatment with teratogenic medications and for an appropriate period after their discontinuation.[3] Long-acting reversible contraception (LARC) is considered very effective, with a failure rate below 1%.[4]

In this issue of the *MJA*, Grzeskowiak and colleagues[5] describe the findings of their retrospective cohort study of the concurrent use of hormonal contraception by women of reproductive age prescribed medicines that are known teratogens (ie, classified as category X by the Therapeutic Goods Administration). Analysing the PBS 10% sample of dispensing data for subsidised medications, the authors found that the rate of dispensing of category X medications to women aged 15–49 years rose from 4.63 per 1000 women in 2013 to 8.70 per 1000 in 2021, predominantly because of increased dispensing of isotretinoin. At the time of their first category X medication dispensing, fewer than one-quarter of women (22.1%) were using any form of hormonal contraception (including oral contraceptives), and only 13.2% were using the more effective hormonal LARC. Among those for whom repeated category X dispensing was recorded, 16.1% had been dispensed a hormonal contraceptive and 11.5% had been dispensed LARC at each category X dispensing.[5]

The analysis by Grzeskowiak and colleagues of the national dispensing data sample provides a representative picture of contemporary dispensing of category X medications to women of reproductive age in Australia, and their findings indicate that their concurrent use of hormonal contraception is inadequate. One of the main limitations of the study is that one form of LARC, the copper intrauterine device (IUD), is not subsidised by the PBS, nor are several hormonal oral contraceptives that are frequently used in Australia.[6] It is therefore likely that the authors underestimated the use of contraception. Although contraceptive overlap was analysed by age, health care concession card status, and state/territory, ethnic background is not included in the PBS data, so that more complete examination of the equity aspects of contraceptive overlap was not possible.

Despite the limitations of the dataset, contraception among women using teratogenic medications is probably unacceptably low. An expert roundtable identified obstacles to LARC use in Australia made recommendations regarding several barriers, including insufficient training of and support for primary care medical practitioners, and access and financial barriers.[7] A Melbourne-based trial has since found that LARC uptake was higher among women who attended general practices where a combination of training in effectiveness-based contraception counselling and rapid referral to a LARC insertion clinic were provided (19% *v* 13% of control group participants).[8] Another trial is assessing whether a nurse-led model increases LARC use in rural and regional areas.[9] Current contraception information is available to support clinicians.[10] However, successful strategies will ultimately require adequate, sustained funding.

Specific action to increase effective contraception by women using teratogenic medications should be a priority. As most dispensing of teratogenic medications to women of reproductive age is of isotretinoin,[5] this medication is an obvious focus. Isotretinoin prescribing in Australia is largely restricted to dermatologists and specialist physicians.[11] As contraception prescribing and LARC insertion are outside their usual scope of practice, women must attend a different health provider for contraception care, which they might not do. General practitioners and nurse practitioners in New Zealand have prescribed subsidised isotretinoin for fifteen years. Although this was predominantly a response to ethnic background- and deprivation-related inequities in access to dermatology services,[12] it could also be advantageous for improving the coordination of contraception prescribing. Perhaps it is time to consider broadening isotretinoin prescribing rights in Australia.

Although LARC overlap was highest among women with health care concession cards in the study by Grzeskowiak and colleagues,[5] suggesting a cost barrier for those without concession cards, LARC use in both groups was low (15.0% and 12.0% respectively). Providing users of category X medications with fully funded contraception and insertion could also be considered.

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