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GLP-1 Baby Boom and Birth Control Failures: Why It's Time to Talk IUDs

Announcer:
You're listening to *Advances in Women's Health* on ReachMD, and this episode is sponsored by Bayer. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
Welcome to *Advances in Women's Health* on ReachMD. I'm your host, Dr. Jennifer Caudle, and joining me to discuss the unexpected rise in pregnancies among GLP-1 users and how we can address it is Dr. Johanna Finkle. She's a weight loss specialist and OB/GYN at the University of Kansas Health System. Dr. Finkle, thank you so much for being here today.

Dr. Finkle:
Thank you so much for having me.

Dr. Caudle:
Of course. To give us some context, Dr. Finkle, can you tell us about the "GLP-1 baby boom" we keep hearing about online and what's driving these unexpected pregnancies?

Dr. Finkle:
Absolutely. So the GLP-1 baby boom, as we call it, is due to an increase in use of GLP-1 receptor agonists, both for diabetes and weight loss. So they've become very popular for weight loss since they're very effective, and patients, especially who are on oral contraceptives, have been having surprise pregnancies. Another factor is that patients who have weight issues often don't ovulate regularly; they may have irregular periods, and we've seen an increase in ovulation that has led to those spontaneous pregnancy rates.

Dr. Caudle:
Okay. Thank you so much. And if we dig a little deeper into the 'why' from a pharmacology standpoint, how might GLP-1 receptor agonists reduce the effectiveness of oral contraceptives?

Dr. Finkle:
And for that, I want to clarify: it's not really all of the GLP-1 receptor agonists. The data shows that tirzepatide is the main issue in terms of the bioavailability of the oral contraceptives. That is thought to be because its mechanism is twofold.

One, it has an increase in vomiting and diarrhea, and that can then decrease the absorption of the oral contraceptive, as well as it has a more significant delay in the absorption of the oral contraceptives. And so because the medication works both in the area of the brain that has satiety and controls satiety but also at the level of the gut that slows down the transit of food, it is thought that the absorption is affected. And in the studies, it shows an impact in the decrease of that bioavailability, making the drugs that are oral contraceptives combined less effective. And so those are the two mechanisms that we think of.

Patients who are experiencing a lot of vomiting and diarrhea should treat the oral contraceptive as though they've missed a pill, so making sure that they follow the recommendations for missing a pill. They need to act as though they have not taken it because it will be less effective. And so the recommendation is to use a backup method when patients are on oral contraceptives, especially during times of an increase in the dosage of the tirzepatide, meaning an escalation in dose, which we do every month.

Dr. Caudle:
And so given some of these concerns, if oral contraceptives may be less effective, what other options are there? What should we be

considering?

Dr. Finkle:
Often, I will talk to my patients about long-acting reversible methods of contraception, and so that would include intrauterine devices, both progesterone and copper IUDs. That intrauterine device will not affect weight, and it provides a long-acting method of contraception that will not interfere with tirzepatide.

Another option that I do discuss is an implant—so an implant in the arm—which is progesterone-only based; that is also not going to be affected by absorption levels that are controlled by tirzepatide. And so that's another option for patients.

And then finally, things that you're not taking orally, like a patch. The caveat with the patch is that there is a maximum weight at which we think the patch is effective, and at that point, it will decrease effectiveness as well.

But those are all options that we talk about with patients, with the IUD being the most effective at 99 percent of prevention of pregnancy.

Dr. Caudle:
Okay, thank you. And going on that point of the IUD, you talked about its effectiveness, but furthermore, what makes IUDs in general an effective alternative for women on GLP-1 therapies?

Dr. Finkle:
So another reason why I talk about intrauterine devices as being a more effective option for patients trying to lose weight is because we know that hormones affect patients differently. And so if they're taking estrogen and progesterone, they may have a stall in their weight loss and other symptoms, including some patients can experience nausea when starting an oral contraceptive. And so when you're taking a GLP-1 and you're taking another medication, you may have an increase in nausea from both of them. And so there's a lot of different reasons why an IUD is something that is more reliable. It doesn't require you to take something every day in addition to your busy schedule, but this is something that you can rely on and then can be easily removed.

Another reason that we talk about it is because patients who have weight issues also have an increased risk for endometrial cancer. And if we're talking about a progesterone-only IUD, it can help prevent endometrial cancer. And I'll talk about that as an added benefit.

Dr. Caudle:
For those of you who are just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Jennifer Caudle, and I'm speaking with Dr. Johanna Finkle about how IUDs can be used to help address the unexpected rise in pregnancies among GLP-1 users.

Now, Dr. Finkel, even though IUDs can help prevent unexpected pregnancies in women on GLP-1 therapy, some patients may still be hesitant. So when you're counseling patients who are starting GLP-1s or even those who are already on them, how do you address that hesitation? And are there any other non-oral options you typically discuss?

Dr. Finkle:
So I think that it's important to meet patients where they're at and to engage in shared decision-making. So in my clinic, my job is to inform patients about that increased risk in pregnancy. But patients may not be comfortable with an intrauterine device or an implant as an alternative to their oral contraceptive. So then I encourage them to use condoms. And so it's participating in an engaged conversation about risks and benefits. That's what we're supposed to do as physicians and as OB/GYNs and then help the patient make an informed decision.

So I have patients who, for example, are very worried about the risk of perforation with an IUD. That risk is minimal. It's 1 in 1,000, but they cannot get past that issue, and so they prefer an oral contraceptive that they can control. That's fine as long as they're using condoms and that they know that if they have an increase in vomiting, they need to follow that missed pill rule.

And so I believe in, again, shared decision-making and informing the patients of all their choices like we talked about: intrauterine devices, implants, and patches. And of course, any method to prevent pregnancy is better than none, right? So if they want to continue with their oral contraceptive, they need to use condoms during the escalation in dosing and initiation.

Dr. Caudle:
That's excellent. And on the subject of counseling, could you share a real-world example of how you frame that risk–benefit conversation with patients?

Dr. Finkle:
Absolutely. The benefit is I'm an OB/GYN and weight management specialist. So when I see a patient who's perimenopausal or below the age of 55, I address contraception. Where are we with that? And prior to prescribing a medication, we have that honest conversation

that ‘this may cause ovulation to increase and for you to have a spontaneous pregnancy. How do you feel about that?’ And a lot of patients will say, ‘I’m not trying to get pregnant at this point. I would like to in the future.’ And a lot of my patients will also want to talk about the risk of teratogenicity, and we're not sure yet. There have been a couple studies on the matter, and we know that there is risk in animal studies. And so I want patients to avoid pregnancy while on GLP-1 receptor agonists.

And so then we discuss the options. And when I discuss the options, of course, intrauterine devices are at the top of my list because, again, they're 99 percent effective. They have the benefit of endometrial cancer prevention, and the bleeding profile is they can achieve amenorrhea. So we can also counsel about that. And so that's what we talk about with patients.

Most of my patients will ask me more questions about an intrauterine device or an implant. What is the bleeding profile? What are the side effects? What are the risks of the procedure? And that's what I go through with them, step by step. And then they can make a decision, and we can proceed with that prior to initiation of the GLP-1 receptor. But I've had patients very open to birth control options, especially long-acting reversible contraceptive methods.

Dr. Caudle:
Now, we recently saw that the Primary Care Women’s Health Forum in the UK released a practical action plan on GLP-1s, oral contraceptives, and even hormone replacement therapy. Why do you think we’re seeing this kind of formal guidance emerge overseas? And is that something we should be considering here in the US?

Dr. Finkle:
I believe the guidance overseas has occurred because there’s an increase in use that’s ubiquitous, and I think that is in response to that increase in use for weight loss. We’re seeing a lot of patients taking even compounded forms of these GLP-1 receptor agonists. And so I think they’re trying to help clinicians create an action plan on how to address contraception and how to inform patients about that decrease in bioavailability from the oral contraceptives.

And I do believe that the US is behind, and we need to catch up to the UK and create our own action plan. When everyone is using a GLP-1 receptor, we really need to help clinicians provide guidance for patients and help provide adequate contraception.

Dr. Caudle:
Agreed. And finally, Dr. Finkle, as GLP-1 use continues to grow for both diabetes and weight management, how do you think this will shape contraceptive counseling going forward?

Dr. Finkle:
So I think that my colleagues who just practice obstetrics and gynecology need to really take a hard look at patients' medication lists. We look at it for a lot of other different reasons. We look at it whether they're on an ACE inhibitor or if they're considering pregnancy and things like that, or when they're on spironolactone and preventing teratogenicity. We look at a lot of other medications, but now we need to have that at the forefront of our thoughts. Are they on a GLP-1? And make sure you ask because some patients are on compounded versions still, and so they may not include it in their medication list. And so we need to be more active in saying, ‘are you on semaglutide or tirzepatide? Have you taken that? How long have you been off of this medication?’ This is another consideration because we would like them to be off of the medication two months prior to conception. And so I think we need to investigate a little bit more during visits.

We need to provide the second component, which is the counseling piece about contraception. We need to inform patients that oral contraception may not be completely effective in preventing pregnancy in patients who are on GLP-1 receptor agonists. So what are their other options? You can use an intrauterine device, an implant in your arm, or you can use a patch—something that is not going to decrease in the bioavailability, meaning something taken orally or that's going to be affected by the side effects of the medications, which tend to be nausea, vomiting, or diarrhea.

So we need to make sure that we understand what the side effects of medications are—again, vomiting and diarrhea—and how they're affecting the bioavailability of our oral medications for prevention of pregnancy.

Dr. Caudle:
As these final comments bring us to the end of today’s program, I’d like to thank my guest, Dr. Johanna Finkle, for joining me to discuss the unexpected rise in pregnancies among GLP-1 users and how IUDs could help address it. Dr. Finkle, it was really great having you on the program today.

Dr. Finkle:
Thank you so much for having me. I really enjoyed this conversation.

Announcer:
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