Women have the opportunity to meet personal contraceptive goals with convenient, highly reliable, and easily reversible methods. Long-acting reversible contraception represents an increasingly popular option for most women throughout the reproductive lifespan. Nonetheless, many women and their health care providers are challenged by coexisting medical issues. We aim to help clinicians individualize contraception and use shared decision-making to enhance patient satisfaction and continuation with their method.

Contraceptive choice is personal, requiring careful consideration and comfort. Women with coexisting health issues require a comprehensive assessment and plan for safe, effective contraception using shared decision-making. The Centers for Disease Control and Prevention (CDC) has published the...
United States Medical Eligibility Criteria for Contraceptive Use (USMEC) which includes evidence-based recommendations for contraceptive management in women with coexisting medical conditions. While it does not replace individualized management, the USMEC classifies method suitability from category 1 to 4 as follows: (1) no restrictions in use; (2) advantages generally outweigh the theoretical or proven risks; (3) theoretical or proven risks usually outweigh the advantages; or (4) unacceptable health risk (should not to be used). Complementary to the USMEC is the 2016 US Selected Practice Recommendations for Contraceptive Use (USSPR) which addresses a select group of common yet potentially controversial or complex issues regarding contraception initiation and use. The USSPR serves as an evidence-based clinical guidance to providers. Also complementary to the USMEC and USSPR are the Quality Family Planning Services which provide for contraceptive counseling/family planning to achieve desired timing of childbirth and infant outcomes. A useful app updated in 2020, developed from the CDC Morbidity and Mortality Weekly Report by the Division of Reproductive Health covering medical conditions (USMEC) and numerous clinical scenarios (USSPR), assists clinicians in counseling women and their partners about contraceptive options and use. Ongoing education using the USMEC assists in the development of evidence-based training bridging knowledge gaps to deliver high-quality contraceptive care.

TIMELY ISSUES IN CONTRACEPTION

Since publication of the original USMEC in 2016, contraceptive experts systematically reviewed timely issues including mood, obesity, heart disease, venous thromboembolism (VTE), injectable contraceptives in adolescents, opioids, and antibiotics. For example, limited evidence found no consistent associations between hormonal contraceptives and postpartum depression. Data showed absolute differences in combined oral contraceptives (COCs) failure by weight and body mass index (BMI) to be small but there was decreased efficacy of the contraceptive patch in the setting of increasing BMI. Women with a history of heart failure can use long-acting reversible contraception (LARC) or permanent sterilization whereas those with a history of uncomplicated cardiac transplantation may use most forms of contraception. In complicated cardiac transplantation, combined hormonal contraceptives (CHCs) and de novo intrauterine system (IUS) insertion are discouraged. In reviewing venous thrombosis among COC users, it is noted that the use of progestogen containing COCs other than levonorgestrel could be associated with a small increased risk of VTE. More than 95% of public-sector providers and office-based physicians consider depomedroxyprogesterone acetate (DMPA) safe for adolescents with only 64% to 89% prescribing DMPA based on factors such as medical specialty, working in settings without government funding, whether offering family planning services, timing of completing medical training, and patient preference for another method. Women can use opioids and contraception with little concern for interactions. Evidence from clinical and pharmacokinetic studies does not support the existence of drug interactions between hormonal contraceptives and non-rifamycin antibiotics.

CURRENT CONTRACEPTIVE USE

For young, nulliparous women and reproductive women between pregnancies or who have completed childbearing, LARC should be the first consideration, with associated US Food and Drug Administration—approved lifespan, including levonorgestrel (LNG) IUS Mirena 52 mg (5 years), Liletta 52 mg (6 years), Kyleena 19.5 mg (5 years), and Skyla 13.5 mg (3 years), the copper TCu380A intrauterine device (IUD) Paragard (10 years), and etonogestrel subdermal implant Nexplanon (3 years). Reported failure rates yearly are 0.05% to 0.8%. Nearly 1 in 4 postpartum women (22.5%) report use of LARC. Factors that affect use of LARC include age, race/ethnicity, education, insurance, parity, intendedness of recent pregnancy, and postpartum visit attendance.
sterilization, an option when childbirth is complete, is also highly effective (0.5% failure rate). In the 65% of women aged 15 to 49 years using contraception, sterilization is used by 18.6%, oral contraceptive pill by 12.6%, and male condoms by 8.7%.14

Injections and CHC (including estrogen and progesterin pills, ring, and patch) have failure rates of 6% to 9% with typical use.2 Barrier methods (condoms, diaphragm, cervical cap, and sponge) and fertility awareness methods have reported failure rates of 12% to 28%.2

This evidence-based review focuses on common medical conditions that can make contraception choices challenging for women and clinicians. Although barrier and other methods are less efficacious than LARC, for some women they may be more acceptable and should be included in discussion regarding shared decision-making. We will discuss contraceptive methods for each condition, listing the methods from most to least effective with typical use.

COMMON MEDICAL CONDITIONS

Cardiac Disease/Hypertension/Diabetes

Approximately 1 in 16 women older than 19 years have coronary artery disease whereas approximately 5.6% of women aged 18 to 39 years and 29.4% of those aged 40 to 59 years have hypertension.15 The prevalence of controlled hypertension is 48.3%.15 Diabetes affects 15 million women in the United States.15 Levonorgestrel (LNG) IUS and TCu380A IUD (together intrauterine contraception [IUC]) are category 1-2 for cardiac disease.1 The LNG IUS and implant are category 3 for continuation in ischemic heart disease given the theoretical concern of progestins on lipids.1 Intrauterine contraception and implant are category 1 for complicated and uncomplicated valvular heart disease and category 1-2 in diabetes and hypertension.1,16 Depot medroxyprogesterone acetate (DMPA) is category 1 for valvular disease, category 2-3 in ischemic heart disease, and category 1-2 in diabetes and hypertension.1 Certain progestin-only contraceptives (POP and DMPA) may increase the risk for thrombosis, although this risk is less than with combined hormonal contraceptives (CHCs).1,17 The effects of DMPA may persist for some time after discontinuation.1,17 CHC are category 3 for uncomplicated valvular disease, blood pressure less than 140 to 159/90 to 99 mm Hg, diabetes without vascular disease and category 4 for a history of multiple risk factors for arterial cardiovascular disease including smokers older than 35 years (15 or more cigarettes daily), women with long-term diabetes or with vascular complications, uncontrolled hypertension, previous myocardial infarction (MI) or cerebrovascular accident (CVA), known ischemic heart or cerebrovascular disease, or complicated valvular heart disease (pulmonary hypertension, risk for atrial fibrillation, and history of subacute bacterial endocarditis).1,17,18 No data exist, but CHC users with adequately controlled and monitored hypertension should be at reduced risk for acute MI and CVA compared with untreated hypertensive CHC users.1 In women with hypertension, COC users were at higher risk than nonusers for CVA, acute MI, and peripheral arterial disease.1,17,18 With hyperlipidemia, CHC is category 2-3.1 It may be beneficial for women with complex cardiac disease, diabetes, and hypertension to be referred to subspecialty care by cardiologists, nephrologists, and gynecologists.

Venous Thromboembolism

Approximately 5% to 8% of the US population has one or more inherited thrombophilias, increasing the risk for thrombosis.15 As many as 900,000 people in the United States yearly may be affected by VTE (1-2/1000) with 60,000 to 100,000 dying of VTE yearly.15 IUS and implant are category 1-2 for VTE.1 In a case-controlled study, DMPA had an odds ratio of 2.2 for VTE whereas LNG IUS, implant, and POP did not show an increased risk.19 The USMEC classifies all progestin only methods as category 2 given that pregnancy confers a much greater risk for VTE.
Routine screening for inherited or acquired thrombophilias is not necessary because of the rarity of the conditions and cost of screening.\textsuperscript{1} Screening women with a family history of a specific thrombophilia is reasonable.\textsuperscript{1} CHC is category 3 with a history of VTE at low risk for recurrence (eg, postoperative).\textsuperscript{1} Combined hormonal contraceptives (so are category 4 with a current VTE, history of VTE with a risk for recurrence (eg, current malignancy), known thrombogenic mutation(s), or upcoming major surgery with prolonged immobilization.\textsuperscript{1}

**Anticoagulation/Bleeding Diathesis**

Bleeding disorders affect approximately 1% of US women and often lead to heavy menses.\textsuperscript{15} Levonorgestrel IUS can be useful to induce amenorrhea while supplying contraception for a known or suspected bleeding diathesis (ie, von Willebrand disease) or during anticoagulation (category 1).\textsuperscript{1,12,20} Any LNG IUS (52 mg, 19.5 mg, and 13.5 mg) can be used, but there may be more breakthrough or persistent menses with lower-dose LNG IUS.\textsuperscript{12} TCu380A IUD, implant, DMPA, and POP are category 1-2. Combined hormonal contraceptives are category 1 for irregular or heavy menses. Combined hormonal contraceptives may be of benefit beyond contraception for women at risk for VTE who use anticoagulation and are at risk of heavy menses.\textsuperscript{21} Use should be individualized. For thalassemias and sickle cell disease, all methods are category 1-2.\textsuperscript{1} Fewer sickle cell crises and fewer anemias have been reported with progesterin-only contraceptives, especially DMPA.\textsuperscript{22}

**Liver Disease**

Liver disease affects approximately 4.5 million Americans yearly.\textsuperscript{15} The number of deaths from liver disease is greater than 41,000 yearly.\textsuperscript{15} TCu380A IUD is category 1 in severe liver cirrhosis, hepatocellular adenoma, and malignant hepatoma.\textsuperscript{1} Levonorgestrel IUS, implant, DMPA, and POP are category 3 in severe liver disease.\textsuperscript{1} Combined hormonal contraceptives are category 4 in women with severe (decompensated) cirrhosis, hepatocellular adenoma, or malignant hepatoma.\textsuperscript{1} For focal nodular hyperplasia (benign), all hormonal contraceptives are category 1-2, whereas for mild (compensated) cirrhosis, all hormonal methods are category 1.\textsuperscript{1} In acute hepatitis, IUC, implant, DMPA, and POP are category 1.\textsuperscript{1} Combined hormonal contraceptives are category 3-4 for an acute flare of hepatitis but category 2 if already being used. For chronic hepatitis, all methods are category 1.\textsuperscript{1} With a history of pregnancy-related cholestasis, CHC is category 2 with other methods category 1.\textsuperscript{1} With a history of cholestasis related to estrogen, CHC is category 3.\textsuperscript{1} When gallbladder disease is a current issue or is being medically treated, CHC is category 3 whereas other methods are category 1-2.\textsuperscript{1}

**Inflammatory Bowel Disease**

Crohn disease and ulcerative colitis affect 1.3% of the US population.\textsuperscript{15} Intrauterine contraceptives and implant are category 1 with DMPA and POP being category 2.\textsuperscript{1} Although CHC has been associated with an increased risk for Crohn disease and ulcerative colitis, causation has not been demonstrated.\textsuperscript{23} Combined hormonal contraceptives may be continued in women with stable bowel disease (category 2-3).\textsuperscript{1}

**Common Connective Tissue Diseases**

Rheumatoid arthritis (RA) is the most common autoimmune arthritis and affects more than 1.5 million Americans with 75% of RA in women.\textsuperscript{24} Intrauterine contraceptives, implant, POP, and CHC are category 1-2 in women on immunosuppressive therapy.\textsuperscript{1} Depot medroxyprogesterone acetate is category 2-3 in women with RA on immunosuppressives.\textsuperscript{1} In RA not requiring immunosuppression all methods are category 1-2.\textsuperscript{1}

It is estimated that 1.5 million Americans have systemic lupus erythematosus (SLE) with 90% being women and the disease often diagnosed between the ages 15 and 44 years.\textsuperscript{15} In the setting of SLE with known or suspected antiphospholipid antibody syndrome (APAS), TCu380A IUD is category 1.\textsuperscript{1,23} Levonorgestrel IUS, implant, and POP are category 3 in known or suspected APAS, and CHC is category 4 in APAS.\textsuperscript{1,25} In the setting of SLE with or without
immunosuppressive use and no evidence of APAS, all methods are category 1-2. In SLE with severe thrombocytopenia, TCu380A IUD and DMPA are category 3 for initiation with all other methods being category 2. TCu380A IUD used in severe thrombocytopenia may be associated with increased bleeding compared with LNG IUS. Progestin-only contraceptives may be useful in women with severe thrombocytopenia. However, DMPA can cause erratic or increased bleeding on initiation and can be irreversible for 11 to 13 weeks. Initiation should be considered carefully.

**Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome**

At the end of 2016, it was estimated that 1.1 million people aged 13 or older have HIV in the United States including an estimated 162,500 (14%) whose infections had not yet been diagnosed. USMEC guidelines were updated for contraception in HIV patients with IUS and DMPA listed as category 1 along with implant, POP, and CHC clarifying that all methods are safe. There is no evidence of greater viral shedding or risk of transmission to an uninfected partner. Limited data show no increased risk of IUC use and pelvic inflammatory disease (PID), but given the risk of concurrent sexually transmitted infections (STIs) in HIV, the USSPR recommends screening for STIs according to CDC guidelines. All methods may be used with antiretrovirals and are listed as category 1-2; CHC is category 3 with use of fosamprenavir.

**Sexually Transmitted Diseases/Infections/ Pelvic Inflammatory Disease**

The CDC reported in its Sexually Transmitted Disease Surveillance Report in 2019 that sexually transmitted diseases for the fifth consecutive year had increased with 2.5 million combined cases of chlamydia, gonorrhea, and syphilis in 2018. While sexually transmitted diseases are increasing, PID is declining potentially related to earlier identification and treatment of chlamydia and gonorrhea with availability of single-dose therapies to enhance adherence to treatment. Intrauterine contraceptives are category 4 for initiation when there is any current suspicion for PID, presence of purulent cervicitis, or known chlamydial or gonococcal infection. If PID develops with IUC in place, it can usually be treated without device removal. A woman is not improved after 48 to 72 hours on antibiotics, consideration can be given to IUC removal. Intrauterine contraceptives are category 2 for evidence of vaginitis with trichomonas and bacterial vaginosis. The CDC’s recommended screening for STIs should be up-to-date before insertion of IUC based on age and risk factors. Delay in insertion is not necessary unless PID is suspected. Implant, DMPA, POP, and CHC are category 1 with STIs, vaginitis, and in women at increased risk of STIs. There is no indication for antibiotic prophylaxis for IUC insertion.

**Solid Organ Transplant(s)/Immunosuppression**

In the United States, the most commonly transplanted organs are kidneys, liver, heart, lungs, pancreas, and intestines. There are approximately 75,000 people on the active transplant list. At least 3% to 4% of the US population is immunosuppressed because of transplantation. For women with solid organ transplant(s), limited studies do not report higher infection rates for immunosuppressed IUC users. Hormonal and non-hormonal IUCs may be initiated and continued in uncomplicated solid organ transplantation as category 2 whereas IUC initiation is category 3 in complicated solid organ transplantation. If the IUS is already in place in complicated solid organ transplantation, it may remain in place (category 2). Implant, DMPA, and POP are category 2. Combined hormonal contraceptives are category 4 for complicated organ transplant but may be used in uncomplicated organ transplant (category 2).
Obesity
Obesity rate (BMI > 30 kg/m²) in the general population is 42.4% with obesity-related conditions including cardiac disease, CVA, type 2 diabetes, and certain cancers. Of the 160 million Americans who are considered overweight (BMI > 25 kg/m²) or obese, 60% are women. Based on a 2016 Cochrane review, obese women can be offered all hormonal contraception as the efficacy of hormonal contraception is not significantly affected. More research is needed to better understand how obesity affects contraceptive efficacy, especially in women with BMI greater than 40 kg/m². It may be possible that continuous COC or 30 to 35 µg estrogen-containing formulations may be more effective in obese women. Evidence regarding efficacy of the patch and ring is limited, but both are more efficacious than barrier methods alone. Concern for VTE risk with use of CHC is outweighed by VTE risk in pregnancy and postpartum. Obese women have a greater risk of abnormal uterine bleeding and endometrial intraepithelial neoplasia (EIN)/hyperplasia. Levonorgestrel 52 mg IUS or other progestin-containing contraception may provide endometrial stabilization and contraception (category 1). If placement of IUC is challenging given high BMI and patient discomfort, sedation can be offered. TCu380A IUD and implant are category 1. Depot medroxyprogesterone acetate is category 1 for women with BMI greater than 30 kg/m² and category 2 for those with BMI greater than 30 kg/m² and age younger than 18 years given risk for mild bone loss. Depot medroxyprogesterone acetate may cause some women to gain up to 5% of their BMI within 6 months of initiation and further weight gain over the next 36 months, whereas other women do not gain weight on DMPA. If weight gain is an issue, alternative contraception includes POP (category 1) and CHC (category 2).

For women undergoing diverting bariatric procedures (Roux-en-Y gastric bypass or biliopancreatic diversion), the absorption of oral medications may be compromised and POP and CHC are category 3.

Migraines
Migraine headaches affect 17.1% of US women most commonly between ages 18 to 44 years. It is important to determine the presence of an aura or focal neurological symptoms before migraine pain. Migraine without aura is most common, accounting for 75% of cases. Aura involves neurological symptoms, usually visual, occurring generally before headache and lasting 5 to 60 minutes. Symptoms include zigzag lines across the visual field, sensory symptoms as pins and needles, speech disturbances, or motor weakness. All methods of contraception are category 1 in non-migraine (mild or severe) headaches. Intrauterine contraceptives, implant, DMPA, and POP are category 1 in women with migraines, with and without aura. Combined hormonal contraceptives are category 2 in migraine without aura and no other risk factors for CVA. If migraines without aura are worsened during the inert week of CHC, continuous CHC may be helpful. Combined hormonal contraceptives are category 4 for women with migraines and aura due to increased CVA risk. The data regarding CVA with current COC formulations in migraines and aura is limited, but earlier formulations have been associated with a two- to four-fold increased CVA risk.

Seizures and Anticonvulsants
Approximately 3.4 million people in the United States have epilepsy. Whereas anticonvulsant therapies challenge contraceptive choice, effective contraception is important because seizure activity may worsen in pregnancy and adversely affect maternal and fetal outcomes. Intrauterine contraceptives are category 1 for women taking antiepileptic drugs (AEDs). Depotmedroxyprogesterone acetate (category 1) 150 mg every 3 months
represents a dose substantially higher than needed to suppress ovulation and confers a benefit in raising the seizure threshold.\textsuperscript{40} Several AEDs induce hepatic enzymes, decreasing serum levels of CHC or POP (category 3) and increasing risk for unintended pregnancy (eg, carbamazepine, barbiturates, phenobarbital, phenytoin, primidone, topiramate, or oxcarbazepine).\textsuperscript{1,41} Combined hormonal contraceptives' efficacy may be improved with 30 to 35 $\mu$g ethinyl estradiol formulations.\textsuperscript{40} It is unclear if the contraceptive ring and patch are similar in efficacy to CHC though the transvaginal and transdermal routes offer the advantage of less need for daily attention.\textsuperscript{41} Most anticonvulsants decrease the effectiveness of the implant (category 2) with some pregnancies reported, but the absolute risk of contraceptive failure remains low.\textsuperscript{42} Lamotrigine is the only AED known to have its metabolism affected by COC, reducing lamotrigine serum levels.\textsuperscript{40} Lamotrigine dosage needs to be adjusted with concurrent CHC use.\textsuperscript{25,40} The POP is category 1 with lamotrigine.\textsuperscript{25} When lamotrigine is used for bipolar disease and other mental health disorders in conjunction with CHC, higher doses of lamotrigine may be needed.\textsuperscript{43}

**Post Abortion**

Intrauterine contraceptives, implant, DMPA, POP, and CHC are category 1-2 and may be immediately used after spontaneous or induced abortion (medical or surgical).\textsuperscript{12} Offering contraception or LARC on the same day of first- or second-trimester induced or spontaneous abortion is safe.\textsuperscript{12} Risk for complications after immediate or delayed IUC insertion following abortion does not differ.\textsuperscript{12} Intrauterine contraceptives expulsion is greater after a second trimester than first trimester abortion.\textsuperscript{1,12} Intrauterine contraceptives insertion immediately post-septic abortion is contraindicated (category 4).\textsuperscript{1}

**Thyroid Disease**

Approximately 20 million Americans have some form of thyroid disease with women more often affected.\textsuperscript{15} Intrauterine contraceptives, implant, DMPA, POP, and CHC are category 1 with simple goiter, hyperthyroidism, or hypothyroidism.\textsuperscript{1}

**Multiple Sclerosis**

Nearly 1 million Americans are living with multiple sclerosis with the prevalence related to latitude (47 per 100,000 population in Texas are affected and 109.5 per 100,000 in Ohio, per the CDC).\textsuperscript{17} Most people receive the diagnosis between 20 and 50 years of age with far more women than men diagnosed.\textsuperscript{15} Intrauterine contraceptives, implant, POP, and CHC are category 1 when mobility is not an issue.\textsuperscript{1} Depot medroxyprogesterone acetate is category 2 with and without prolonged immobility whereas CHC is category 3 with prolonged immobility.\textsuperscript{1}

**Cervical Cancer**

Cervical cancer occurs in greater than 13,500 women yearly in the United States.\textsuperscript{15} Cervical cancer is most frequently diagnosed in women between ages 35 and 44 years.\textsuperscript{15} Intrauterine contraceptives are category 4 with known cervical cancer.\textsuperscript{1} Implant, DMPA, POP, and CHC can be used while women are awaiting treatment (category 1-2).\textsuperscript{1,25} All methods can be used with cervical ectropion, cervical intraepithelial neoplasia, or dysplasia.\textsuperscript{1} Depot medroxyprogesterone acetate or CHC use for 5 years or longer may increase the risk for carcinoma in situ and invasive cervical cancer in the setting of persistent human papillomavirus.\textsuperscript{44} Limited evidence suggests that the implant does not increase risk.\textsuperscript{1} Invasive cervical cancer may be reduced by 30% in women who have used IUCs.\textsuperscript{45}

**Endometrial Cancer/Endometrial Hyperplasia or Endometrial Intraepithelial Neoplasia**

Endometrial cancer is on the rise in the United States with lifetime risk 3.1%.\textsuperscript{15} Black women are disproportionately affected compared with White women.\textsuperscript{15} The increase in endometrial cancer reflects the prevalence of overweight and obese women

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\textsuperscript{25} www.mayoclinicproceedings.org
along with other risk factors such as hypertension and diabetes.\textsuperscript{15} Intrauterine contraceptives are category 4 in known endometrial cancer but endometrial hyperplasia/EIN may regress or remain stable while using 52 mg LNG IUS.\textsuperscript{33} Implant, DMPA, POP, and CHC are category 1.\textsuperscript{1} Contraception (including COC and 52 mg LNG IUS) plays a dual role in minimizing the risk of endometrial cancer.\textsuperscript{33,46}

**Gestational Trophoblastic Disease**

Gestational trophoblastic disease (GTD) occurs in approximately 1 per 1000 pregnancies.\textsuperscript{25} Intrauterine contraceptives are category 1-2 in GTD but category 4 with persistently elevated beta-human chorionic gonadotropin (hCG) levels or malignant disease with suspicion of intrauterine involvement. Implant, DMPA, POP, and CHC are category 1 in GTD when beta-hCG levels are decreasing or undetectable and may be used with persistently elevated beta-hCG levels or malignant disease (category 1).\textsuperscript{1,25}

**Ovarian Cancer**

The incidence of ovarian cancer in the United States results in 14,000 deaths annually.\textsuperscript{15} Ovarian cancer continues to be diagnosed at an advanced stage in most women. Intrauterine contraceptives, implant, DMPA, POP, and CHC are category 1 in ovarian cancer. Data show that COC lessens the risk of ovarian cancer as does use of IUC in a new meta-analysis.\textsuperscript{46,47}

**Breast Cancer**

Breast cancer is the most common cancer in women.\textsuperscript{15} Lifetime risk of breast cancer is approximately 12.9%.\textsuperscript{15} TCu380A IUD is category 1 in breast cancer. Levonorgestrel IUS, implant, DMPA, POP, and CHC are category 4 given that most breast cancers are hormonally active due to concern for worsened prognosis.\textsuperscript{1} In benign breast disease or with a family history of breast cancer, all methods are category 1.\textsuperscript{1,25} Care for BRCA 1 and 2 carriers is more complex given their risk for breast and ovarian cancer. A systematic review recommended that BRCA carriers be informed that COC may reduce risk of ovarian cancer but potentially increase risk for breast cancer.\textsuperscript{48}

**SUMMARY**

Women’s coexisting medical conditions often challenge contraceptive decisions as recommendations evolve. Long-acting reversible contraception should be the first line of options for most women throughout the reproductive lifespan given their efficacy, convenience, and safety. However, other methods should also be considered as they may confer a lower risk than unplanned pregnancy. Resources such as the USMECT, USSPR, and the USMECT app facilitate the contraceptive choice process by providing expert and evidence-based support for individualized assessment and shared decision-making.

**CONCLUSION**

It is important to individualize contraception through shared decision-making in women with chronic medical conditions.

**Abbreviations and Acronyms:**

- BMI = body mass index
- CDC = Centers for Disease Control and Prevention
- CHC = combined hormonal contraceptives
- COC = combined oral contraceptives
- CVA = cerebral vascular event
- DMPA = depot medroxyprogesterone acetate
- EIN = endometrial intraepithelial neoplasia
- IUC = intrauterine contraception
- IUD = intrauterine device
- IUS = intrauterine contraceptive system
- LARC = long-acting reversible contraception
- LNG = levonorgestrel
- MI = myocardial infarction
- POP = progestin only pill
- STI = sexually transmitted infection
- USMECT = United States Medical Eligibility Criteria for Contraceptive Use
- USSPR = US Selected Practice Recommendations for Contraceptive Use
- VTE = venous thromboembolism

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**REFERENCES**

41. Galfeld ME, Culwell KR, Lee CR. The use of hormonal contraception among women taking anticonvulsant therapy. Contra-
43. Prabhavalkar KS, Poovanpallil NB, Bhatt LK. Management of bi-
polar depression with lamotrigine: an antiepileptic mood stabil-
44. Smith JS, Green J, Berrington de Gonzalez A. Cervical cancer and use of hormonal contraceptives: a systematic review. Lanc-
45. Cortessis VK, Barrett M, Brown Wade N, et al. Intrauterine device use and cervical cancer risk: a systematic review and meta-
47. Wheeler LJ, Desanto K, Teal SB, Sheeder J, Guntupalli SR. Intra-