

## POLICY & PRACTICE

### Calif. Stem Cell Initiative Advances

Stem cell research efforts took another step forward in California when a state appeals panel ruled that an initiative to provide billions in funding for human embryonic stem cell research is constitutional. In 2004, voters approved Proposition 71, the California Stem Cell Research and Cures Act, which authorized the distribution of \$3 billion in funding over 10 years. The initiative was challenged by two taxpayer advocacy groups and the California Family Bioethics Council for not revealing the entire scope of the project and for al-

lowing for the distribution of state funds to groups not under the exclusive control of the state. A challenge to the proposition was defeated last year and the appeals panel rejected an appeal last month. In the meantime, the initiative has been moving forward and recently approved its first round of grants. The 72 grants, which will be funded with \$45 million over 2 years, were selected from among more than 200 applications. The grants will fund various projects including the generation of a library of human embryonic stem cell lines that can model a number of human

genetic diseases and experiments into how mutations in mitochondria affect the stability of human embryonic stem cells and their ability to develop into nerve cells.

### Women's Health at the FDA

Sens. Hillary Rodham Clinton (D-N.Y.), Olympia Snowe (R-Maine), Patty Murray (D-Wash.), and Barbara Mikulski (D-Md.) have written a letter to Food and Drug Administration Commissioner Dr. Andrew von Eschenbach urging him to retain full funding for the agency's Office of Women's Health. "According to news reports, the FDA intends to reallocate \$1.2 million in funding from the fiscal year

2007 budget of the Office of Women's Health to other uses. ... As Congress moves forward with the budget and appropriations process, we will pursue every course to make certain that this funding is restored," the senators said in the letter, noting that Congress had allocated \$4 million for the office. Phyllis Greenberger, president and CEO of the Society for Women's Health Research, noted that because the proposed cut represents a big chunk of the office's budget, it will probably have to shut down operations for the remainder of the year should the cut be made. "FDA leaders erroneously believe its various centers can fully address women's health needs on their own, something they have not demonstrated," she said in a statement.

### Implementing Routine HIV Testing

Physicians need new tools and resources in order to implement revised recommendations for routine HIV testing of all patients aged 13-64 years from the Centers for Disease Control and Prevention, according to the consensus of various medical professional societies including the American College of Obstetricians and Gynecologists. ACOG was among the groups convened last year by the American Academy of HIV Medicine and the American Medical Association, in cooperation with the CDC, to discuss how best to implement the CDC's "Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings." The American Academy of HIV Medicine released a summary of the discussions in February. For example, physicians will need resources that systematically describe how to provide both positive and negative results to patients.

### Assisted Reproductive Data Available

The Society for Assisted Reproductive Technology has released data on the success rates of its member clinics in 2005. The organization collected data from 343 clinics, which reported data on 122,683 treatment cycles in 2005. This is the second year that SART had published this type of outcome data. The information, which is available online at [www.sart.org](http://www.sart.org), is organized by state. Patients and physicians can see a summary page for each clinic and sort outcome data by diagnosis and treatment type. Patients can also use the Web site to request information directly from a clinic.

### HEART for Women Reintroduced

The American Heart Association is throwing its weight behind the Heart Disease Education, Analysis and Research, and Treatment (HEART) for Women Act, which was reintroduced in both the House and Senate last month. Sponsored by Sen. Debbie Stabenow (D-Mich.) and Sen. Lisa Murkowski (R-Alaska), the legislation authorizes the Health and Human Services department to provide education to older women and health care professionals on the diagnosis and treatment of women with heart disease, requires gender-specific reporting of heart disease data to the federal government, and expands WISE-WOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation), the free heart disease and stroke screening program, beyond its current 14 states.

—Mary Ellen Schneider



Rx only. For vaginal use only.  
Brief Summary of Full Prescribing Information

**Women should be counseled that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases.**  
**INDICATIONS AND USAGE:** NuvaRing® is indicated for the prevention of pregnancy in women who elect to use this product as a method of contraception. Like oral contraceptives, NuvaRing® is highly effective if used as recommended in this label. In three large clinical trials of 13 cycles of NuvaRing® use, pregnancy rates were between one and two per 100 women-years of use. Table III lists the pregnancy rates for users of various contraceptive methods.

#### WARNINGS

**Cigarette smoking increases the risk of serious cardiovascular side effects from combination oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use combination hormonal contraceptives, including NuvaRing®, should be strongly advised not to smoke.**

NuvaRing® and other contraceptives that contain both an estrogen and a progestin are called combination hormonal contraceptives. There is no epidemiologic data available to determine whether safety and efficacy with the vaginal route of administration of combination hormonal contraceptives would be different than the oral route. The use of oral contraceptives is associated with increased risks of several serious conditions including myocardial infarction, thromboembolism, stroke, hepatic neoplasia, and gallbladder disease, although the risk of serious morbidity or mortality is very small in healthy women without underlying risk factors. The risk of morbidity and mortality increases significantly in the presence of other underlying risk factors such as hypertension, hyperlipidemias, obesity, and diabetes. The information contained in this package insert is principally based on studies carried out in women who used oral contraceptives with formulations of higher doses of estrogens and progestogens than those in common use today. The effect of long-term use of oral contraceptives with lower doses of both estrogens and progestogens remains to be determined. Throughout this labeling, epidemiologic studies reported are of two types: retrospective or case control studies and prospective or cohort studies. Case control studies provide a measure of the relative risk of the incidence of a disease among oral contraceptive users to that among non-users. The relative risk does not provide information on the actual clinical occurrence of a disease. Cohort studies provide a measure of attributable risk, which is the difference in the incidence of disease between oral contraceptive users and non-users. The attributable risk does provide information about the actual occurrence of a disease in the population. For further information, the reader is referred to a text on epidemiologic methods. **1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS.** a. Thromboembolism. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Case control studies have found the relative risk of users compared to non-users to be three for the first episode of superficial venous thrombosis, four to 11 for deep vein thrombosis or pulmonary embolism, and 1.5 to six for women with predisposing conditions for venous thromboembolic disease. Cohort studies have shown the relative risk to be somewhat lower, about three for new cases and about 4.5 for new cases requiring hospitalization. The risk of thromboembolic disease associated with oral contraceptives is not related to length of use and disappears after pill use is stopped. Several epidemiologic studies indicate that third generation oral contraceptives, including those containing desogestrel (etonogestrel), the progestin in NuvaRing®, is the biologically active metabolite of desogestrel, are associated with a higher risk of venous thromboembolism than certain second generation oral contraceptives. In general, these studies indicate an approximate two-fold increased risk, which corresponds to one to two cases of venous thromboembolism per 10,000 women-years of use. However, data from additional studies have not shown this two-fold increase in risk. It is unknown if NuvaRing® has a different risk of venous thromboembolism than second generation oral contraceptives. A two- to four-fold increase in relative risk of post-operative thromboembolic complications has been reported with the use of oral contraceptives. The relative risk of venous thrombosis in women who have predisposing conditions is twice that of women without medical conditions. If feasible, combination hormonal contraceptives, including NuvaRing®, should be discontinued at least four weeks prior to and for two weeks after elective surgery of a type associated with an increased risk of thromboembolism and during and following prolonged immobilization. Since the relative risk of heart attack for current combination oral contraceptive users has been estimated to be two to six, the risk is very low in women under the age of 30. Smoking in combination with oral contraceptive use has been shown to contribute substantially to the incidence of myocardial infarction in women in their mid-thirties or older with smoking accounting for the majority of excess cases. Mortality rates associated with circulatory disease have been shown to increase substantially in smokers, over the age of 35 and non-smokers over the age of 40 among women who use oral contraceptives. Oral contraceptives may compound the effects of well-known risk factors, such as hypertension, diabetes, hyperlipidemias, age, and obesity. In particular, some progestogens are known to decrease HDL cholesterol and cause glucose intolerance, and estrogens may be associated with an increased risk of myocardial infarction. Oral contraceptives have been shown to increase blood pressure among users (see WARNINGS). Similar effects on risk factors have been associated with an increased risk of heart disease. NuvaRing® must be used with caution in women with cardiovascular disease risk factors. c. Cerebrovascular diseases. Oral contraceptives have been shown to increase both the relative and attributable risks of cerebrovascular events (thrombotic and hemorrhagic strokes), although, in general, the risk is greatest among older (>35 years), hypertensive women who also smoke. Hypertension was found to be a risk factor for both users and non-users, for both types of strokes, while smoking interacted to increase the risk for hemorrhagic strokes. In a large study, the relative risk of thrombotic strokes has been shown to range from three for non-smokers under age 14 for users with severe hypertension. The relative risk of hemorrhagic stroke is reported to be 1.2 for non-smokers who used oral contraceptives, 2.6 for smokers who did not use oral contraceptives, 7.6 for smokers who used oral contraceptives, 1.8 for non-smokers under age 14 and 25.7 for users with severe hypertension. The attributable risk is also greater in older women. d. Dose-related risk of vascular disease from oral contraceptives. A positive association has been observed between the amount of estrogen and progestogen in oral contraceptives and the risk of vascular disease. A decline in serum high-density lipoprotein (HDL) has been reported with many progestational agents. A decline in serum HDL levels has been associated with an increased incidence of ischemic heart disease. Because estrogens increase HDL cholesterol, the net effect of an oral contraceptive depends on a balance achieved between doses of estrogen and progestogen and the nature and absolute amount of progestogens used in the contraceptives. The activity and amount of both hormones should be considered in the choice of a hormonal contraceptive. e. Persistence of risk of vascular disease. There are two studies that have shown persistence of risk of vascular disease for ever-users of oral contraceptives. In a study in the United States, the risk of developing myocardial infarction after discontinuing oral contraceptives persists for at least nine years for women 40-49 years old who had used oral contraceptives for five or more years, but this increased risk was not demonstrated in other age groups. In another study in Great Britain, the risk of developing cerebral disease persisted for at least six years after discontinuation of oral contraceptives, although excess risk was very small. However, both studies were performed with oral contraceptive formulations containing 50 micrograms or more of estrogen. It is unknown whether NuvaRing® is distinct from combination oral contraceptives with regard to the occurrence of venous or arterial thrombosis. **2. ESTIMATES OF MORTALITY FROM CONTRACEPTIVE USE.** One study gathered data from a variety of sources that have estimated the mortality rate associated with different methods of contraception at different ages (Table V in the full prescribing information). These estimates include the combined risk of death associated with contraceptive methods and the risk attributable to non-contraceptive causes. Each method of contraception has its own benefits and risks. The study concluded that with the exception of oral contraceptive users age 35 and older who smoke and age 40 and older who do not smoke, mortality associated with all methods of birth control is low and below that associated with childbirth. The observation of a possible increase in risk of mortality with age for oral contraceptive users is based on data gathered in the 1970's, but not reported until 1983. However, current clinical practice involves the use of lower estrogen-dose formulations combined with careful consideration of risk factors. Because of these changes in practice and also, because of some limited new data which suggest that the risk of cardiovascular disease with the use of oral contraceptives may now be less than previously observed, the Family and Maternal Health Advisory Committee was asked to review the topic in 1989. The Committee concluded that although cardiovascular disease risks may be increased with oral contraceptive use after age 40 in healthy non-smoking women (even with the newer low-dose formulations), there are also greater potential health risks associated with pregnancy in older women and with the alternative surgical and medical procedures which may be necessary if such women do not have access to effective and acceptable means of contraception. Therefore, the Committee recommended that the benefits of low-dose oral contraceptive use by healthy non-smoking women over 40 may outweigh the possible risks. Although the data are mainly for oral contraceptives, this is likely to apply to NuvaRing® as well. Women of all ages who take hormonal contraceptives should take the lowest possible dose formulation that is effective and meets the needs of the individual woman. **3. CARCINOMA OF THE REPRODUCTIVE ORGANS AND BREASTS.** Numerous epidemiologic studies have been performed on the incidence of breast, endometrial, ovarian, and cervical cancer in women using combination oral contraceptives. The risk of having breast cancer diagnosed may be slightly increased among current and recent users of combination oral contraceptives. However, this excess risk appears to decrease over time after COC discontinuation and by 10 years after cessation the increased risk disappears. Some studies report an increased risk with duration of use while other studies do not and no consistent relationships have been found with dose or type of steroid. Some studies have found a small increase in risk for women who first use COCs before age 20. Most studies show a similar pattern of risk with COC use regardless of a woman's reproductive history or her family breast cancer history. In addition, breast cancers diagnosed in current or ever oral contraceptive users may be less clinically advanced than in never-users. Women who currently have or have had breast cancer should not use hormonal contraceptives because breast cancer is usually a hormonally sensitive tumor. Some studies suggest that combination oral contraceptive use has been associated with an increase in the risk of cervical intraepithelial neoplasia in some populations of women. However, there continues to be controversy about the extent to which such findings may be due to differences in sexual behavior and other factors. In spite of many studies of the relationship between oral contraceptive use and breast and cervical cancers, a cause-and-effect relationship has not been established. It is unknown whether NuvaRing® is distinct from oral contraceptives with regard to the above statements. **4. HEPATIC NEOPLASIA.** Benign hepatic adenomas are associated with oral contraceptive use, although the incidence of benign tumors is rare in the United States. Indirect calculations have estimated the attributable risk to be in the range of 3.3 cases per 100,000 for users, a risk that increases after four or more years of use. Rupture of rare, benign, hepatic adenomas may cause death through intra-abdominal hemorrhage. Studies from Britain have shown an increased risk of developing hepatocellular carcinoma in long-term (>8 years) oral contraceptive users. However, these cancers are extremely rare in the US and the attributable risk (the excess incidence) of liver cancers in oral contraceptive users approaches less than one per million users. It is unknown whether NuvaRing® is distinct from oral contraceptives in this regard. **5. OCULAR LESIONS.** There have been clinical case reports of retinal thrombosis associated with the use of oral contraceptives. NuvaRing® should be discontinued if there is unexplained partial or complete loss of vision, onset of proptosis or diplopia, papilledema, or retinal vascular lesions. Appropriate diagnostic and therapeutic measures should be undertaken immediately. **6. HORMONAL CONTRACEPTIVE USE BEFORE OR DURING EARLY PREGNANCY.** Hormonal contraceptives should not be used during pregnancy. Extensive epidemiologic studies have revealed no increased risk of birth defects in women who have used oral contraceptives prior to pregnancy. Studies also do not suggest a teratogenic effect, particularly in so far as cardiac anomalies and limb reduction defects are concerned, when oral contraceptives are taken inadvertently during early pregnancy. Combination hormonal contraceptives, such as NuvaRing®, should not be used to induce withdrawal bleeding as a test for pregnancy. NuvaRing® should not be used during pregnancy to treat threatened or habitual abortion. It is recommended that for any woman who has not adhered to the prescribed regimen for use of NuvaRing® and has missed a menstrual period or who has missed two consecutive periods, pregnancy should be ruled out. **7. GALLBLADDER DISEASE.** Combination hormonal contraceptives, such as NuvaRing®, may worsen existing gallbladder disease and may accelerate the development of this disease in previously asymptomatic women. Women with a history of combination hormonal contraceptive-related cholelithiasis are more likely to have the condition recur with subsequent combination hormonal contraceptive use. **8. CARBOHYDRATE AND LIPID METABOLIC EFFECTS.** Hormonal contraceptives have been shown to cause a decrease in glucose tolerance in some users. However, in the non-diabetic woman, combination hormonal contraceptives appear to have no effect on fasting blood glucose levels. Prediabetic and diabetic women should be carefully observed while taking combination hormonal contraceptives, such as NuvaRing®. In a clinical study involving 37 NuvaRing®-treated subjects, glucose tolerance

tests showed no clinically significant changes in serum glucose levels from baseline to cycle six. A small proportion of women will have persistent hyperglycemia while using oral contraceptives. Changes in triglyceride and lipoprotein levels have been reported in combination hormonal contraceptive users. **ELEVATED BLOOD PRESSURE.** An increase in blood pressure has been reported in women taking oral contraceptives and this increase is more likely in older oral contraceptive users and with continued use. Data from the Royal College of General Practitioners and subsequent randomized trials have shown that the incidence of hypertension increases with increasing concentrations of progestogens. Women with a history of hypertension or hypertension-related diseases, or renal disease should be encouraged to use another method of contraception. If these women elect to use NuvaRing®, they should be monitored closely and if significant elevation of blood pressure occurs, NuvaRing® should be discontinued. For most women, elevated blood pressure will return to normal after stopping hormonal contraceptive use, but there is no inference in the occurrence of hypertension between former and never-users. **10. HEADACHE.** The onset or exacerbation of migraine or development of headache with a new pattern which is recurrent, persistent, or severe requires discontinuation of NuvaRing® and evaluation of the cause. **11. BLEEDING IRREGULARITIES.** Bleeding Patterns. Breakthrough bleeding and spotting are sometimes encountered in women using NuvaRing®. If abnormal bleeding while using NuvaRing® persists or is severe, appropriate investigation should be instituted to rule out the possibility of organic pathology or pregnancy, and appropriate treatment should be instituted when necessary. In the event of amenorrhea, pregnancy should be ruled out. Bleeding patterns were evaluated in three large clinical studies. In the US-Canadian study (n=1177), the percentages of subjects with breakthrough bleeding/spotting ranged from 7.2 to 11.7% during cycles 1-13. In the two non-US studies, the percentages of subjects with breakthrough bleeding/spotting ranged from 2.6 to 6.4% (Study 1, n=1145 European and Israeli subjects) and from 2.0 to 8.7% (Study 2, n=512 European and South American subjects). In these three studies, the percentages of women who did not have withdrawal bleeding in a given cycle ranged from 0.3 to 3.8%. Some women may encounter amenorrhea or oligomenorrhea after discontinuing use of NuvaRing®, especially when such a condition was pre-existent. **12. ECTOPIC PREGNANCY.** Ectopic as well as intrauterine pregnancy may occur with contraceptive failures. **PRECAUTIONS.** **1. GENERAL.** Women should be counseled that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases. **2. PHYSICAL EXAMINATION AND FOLLOW-UP.** It is routine medical practice for women using NuvaRing®, as for all women, to have an annual medical evaluation including physical examination and relevant laboratory tests. The physical examination should include special reference to blood pressure, breasts, abdomen, pelvic organs and vagina (including cervical cytology). In case of undiagnosed, persistent or recurrent abnormal vaginal bleeding, appropriate measures should be conducted to rule out malignancy. Women with a family history of breast cancer or who have breast nodules should be monitored with particular care. **3. LIPID DISORDERS.** Women with a history of hyperlipidemia should be followed closely if they elect to use NuvaRing®. Some progestogens may elevate LDL levels and may render the control of hyperlipidemias more difficult. **4. LIVER FUNCTION.** If jaundice develops in any woman using NuvaRing®, product use should be discontinued. The hormones in NuvaRing® may be poorly metabolized in women with impaired liver function. **5. FLUID RETENTION.** Steroid hormones like those in NuvaRing®, may cause some degree of fluid retention. NuvaRing® should be prescribed with caution, and only with careful monitoring, in women with conditions which might be aggravated by fluid retention. **6. EMOTIONAL DISORDERS.** Women who become significantly depressed while using combination hormonal contraceptives, such as NuvaRing®, should stop the medication and use another method of contraception in an attempt to determine whether the symptom is drug related. Women with a history of depression should be carefully observed and NuvaRing® discontinued if significant depression occurs. **7. TAMPON USE.** On rare occasions, NuvaRing® may be expelled while removing a tampon (see EXPULSION). Pharmacokinetic data show that the use of tampons has no effect on the systemic absorption of the hormones released by NuvaRing®. **8. TOXIC SHOCK SYNDROME (TSS).** Cases of toxic shock syndrome have been associated with tampons and certain barrier contraceptives. Very rare cases of TSS have been reported by NuvaRing® users; in some cases the women were also using tampons. No causal relationship between the use of NuvaRing® and TSS has been established. If a patient exhibits signs or symptoms of TSS, the possibility of this diagnosis should not be excluded and appropriate medical evaluation and treatment initiated. **9. CONTACT LENSES.** Contact lens wearers who develop visual changes or changes in lens tolerance should be assessed by an ophthalmologist. **10. DRUG INTERACTIONS.** Changes in Contraceptive Effectiveness Associated with Co-Administration of Other Drugs. Contraceptive effectiveness may be reduced when hormonal contraceptives are co-administered with some antifungals, anticonvulsants, and other drugs that increase metabolism of contraceptive steroids. This could result in unintended pregnancy or breakthrough bleeding. Examples include barbiturates, griseofulvin, rifampin, phenylbutazone, phenytoin, carbamazepine, felbamate, oxcarbazepine, topiramate, and modafinil. Women may notice a change in their menstrual cycle when taking such medications. Several of the anti-HIV protease inhibitors have been studied with co-administration of oral combination hormonal contraceptives; significant changes (increases and decreases) in the mean AUC of the estrogen and progestin have been noted in some cases. The efficacy and safety of oral contraceptive products may be affected; it is unknown whether this applies to NuvaRing®. Healthcare providers should refer to the label of the individual anti-HIV protease inhibitors for further drug-drug interaction information. Herbal products containing St. John's Wort (hypericum perforatum) may induce hepatic enzymes (cytochrome P450) and p-glycoprotein transporter and may reduce the effectiveness of combination hormonal contraceptives, including NuvaRing®, by increasing their metabolism. **11. Changes in Plasma Levels of Co-Administered Drugs.** Combination hormonal contraceptives containing some synthetic estrogens (e.g., ethinyl estradiol) may inhibit the metabolism of other compounds. Increased plasma concentrations of cyclosporine, indinavir, and theophylline have been reported with concomitant administration of oral contraceptives. In addition, oral contraceptives may induce the conjugation of other compounds. Decreased plasma concentrations of acetaminophen and increased clearance of tetracycline, salicylic acid, morphine and clofibrate acid have been noted when these drugs were administered with oral contraceptives. **11. INTERACTIONS WITH LABORATORY TESTS.** Certain endocrine and liver function tests and blood components may be affected by combined hormonal contraceptives: a. Increased prothrombin and factors VII, VIII, IX and X; decreased antithrombin III; increased norepinephrine-induced platelet aggregability. b. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by radioimmunoassay, Free T4 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered. c. Other binding proteins may be elevated in serum. d. Sex hormone-binding globulins are increased and result in elevated levels of total circulating sex steroids; however, free or biologically active levels either decrease or remain unchanged. e. Triglycerides may be increased and levels of various other lipids and lipoproteins may be affected. f. Glucose tolerance may be decreased. g. Serum folate levels may be depressed by oral contraceptive therapy. This may be of clinical significance if a woman becomes pregnant shortly after discontinuing NuvaRing®. **12. CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY.** In a 24-month carcinogenicity study in rats with subdermal implants releasing 10 and 20 µg ethinyl estradiol per day, (approximately 0.3 and 0.6 times the systemic steady-state exposure of women using NuvaRing®), no drug-related carcinogenic potential was observed. Etonogestrel was not genotoxic in the *in vitro* Ames/Salmonella reverse mutation assay, the chromosomal aberration assay in Chinese hamster ovary cells or in the *in vivo* mouse micronucleus test. Fertility returned after withdrawal from treatment (see WARNINGS). **13. PREGNANCY.** Pregnancy Category X (see CONTRAINDICATIONS in the full prescribing information and WARNINGS). Teratology studies have been performed in rats and rabbits using the oral route of administration at doses up to 130 and 260 times, respectively, the usual human dose (based on body surface area) and have revealed no evidence of harm to the fetus or to the offspring. **14. NURSING MOTHERS.** The effects of NuvaRing® on milk production, milk volume, and milk composition are unknown. Small amounts of contraceptive steroids have been identified in the milk of nursing mothers and a few adverse effects on the child have been reported, including jaundice and breast enlargement. In addition, contraceptive steroids given in the postpartum period may interfere with lactation by decreasing the quantity and quality of breast milk. Long-term follow-up of children whose mothers used combination hormonal contraceptives while breast-feeding has shown no deleterious effects on infants. However, women who are breast-feeding should be advised not to use NuvaRing® but to use other forms of contraception until the child is weaned. **15. PEDIATRIC USE.** Safety and efficacy of NuvaRing® in children has not been established. **16. CONTRAINDICATIONS.** The following conditions are contraindications to the use of NuvaRing®: **1. NURSING MOTHERS.** The effects of NuvaRing® on milk production, milk volume, and milk composition are unknown. Small amounts of contraceptive steroids have been identified in the milk of nursing mothers and a few adverse effects on the child have been reported, including jaundice and breast enlargement. 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