EMERGENCY CONTRACEPTION – WHICH OPTION WHEN: PART 2

Consultant sexual and reproductive health expert Dr Anne Webb answers more questions on emergency contraception

Q What choices should the woman be offered?

A Every woman should be offered all possible options. The only exception is when there is a good medical reason to restrict choice. If a health professional is not able to provide all options straight away, referral pathways should be in place to enable a woman to have her choice within the tight time limits to ensure the methods will still be effective.

When referring on for an alternative method, whatever is available should be offered. This is because the patient may get delayed in getting an intrauterine device or ulipristal, and both oral methods should be used as soon as possible. Also, it can never be guaranteed that an intrauterine device can be fitted, and if oral treatment was not given at the first opportunity, then the window of action may have passed.

Q How can the advantages and disadvantages of each method be summarised for the patient?

A **The copper intrauterine device**: The greatest advantage is it works. It also gives long term contraception for five to ten years. Very little follow up is required. A great "fit and forget", method. It can always be fitted up to five days after the first risk and often later. This depends on when the risk was in the cycle in relationship to when implantation could start, which is never before five days after ovulation.

It needs to be fitted, which can be uncomfortable, and the patient will need a visit to a GP practice or clinic that is set up to do it. That may mean that it cannot be done on the day of the request but there is no need to worry about any reduction in effectiveness with the passage of time. If there is any delay it is worth taking oral EC in the interim, just in case the fitting is not possible on the day. If there is any risk of a previous pregnancy already being in the womb, a copper intrauterine device cannot be fitted. A follow up at six weeks is widely suggested, but the key is to teach woman to check her IUD/S threads and only attend if she has a problem, it expires, or she wants it removed.

Ulipristal: This tablet works for most of the risk time in the cycle. It is licenced up to 120 hours from the first risk but at present still requires a woman to see a nurse or doctor. It has virtually no side effects. It should be taken as early as possible as this increases the chances of success. Women who take certain medications which interact with it cannot use it and there are a few rare conditions that limit its use. Starting ongoing hormonal contraception straight after using ulipristal contraceptive cover takes longer to be established so it is necessary to use extra precautions for an extra week. It is necessary to do a pregnancy test if a woman has not had a normal bleed within three weeks of taking ulipristal, as a pregnancy can still happen.

Steps towards removing the need for a prescription for ulipristal have been taken with the European Medicines Agency and the European Commission authorised it to be accessible direct from pharmacies from January 2015 without the need for prescription from a doctor.

Levonorgesterel: This tablet reduces the risk of pregnancy though it is not as effective as ulipristal. It is licenced to be used up to 72 hours but may give some protection later. It is widely available, easy to swallow and has virtually no side effects. There are no women who cannot take it for medical reasons, though on occasion women may need to double the dose if they take certain medications, such as some antiepilileptics. It should be taken as early as possible as this increases the chances of success. Most hormonal contraception can be started at the same time as taking levonorgesterel, and contraceptive cover will be achieved between two (for progestogen only pills), seven (implant and injectable contraception and most combined pills) and nine days (Qlaira).[1] It is necessary to do a pregnancy test if a woman has not had a normal bleed within three weeks of taking levonorgesterel as a pregnancy can still happen.

Q When can ongoing contraception be started?

A Studies have shown that up to 30% of women have further unprotected intercourse after using EC and before their next bleed.[2] Addressing ongoing contraception at the same time is therefore essential.

The copper intrauterine device offers long term contraception for five to ten years depending on the device.

All hormonal methods, other than the intrauterine system, can be started on the same day as the oral EC is taken. This is referred to as "quick starting", and there are national guidelines detailing recommended practice.[7] After levonorgesterel contraceptive cover will be established between two (for progestogen only pills), seven (implant and injectable contraception and most combined pills) and nine days (Qlaira) and after ulipristal between nine (for progestogen only pills), 14 (implant and injectable contraception and most combined pills) and 16 days (Qlaira).[2]

All hormonal methods, other than the intrauterine system, can be started on the same day as the oral EC is taken

Q Are there any age limits?

A Any woman between menarche and menopause who is at risk of pregnancy should be offered all eligible methods of EC. If there are any safeguarding children or adult issues these should also be addressed, but oral EC should not be delayed as this could limit its effectiveness.

All professionals should have effective referral pathways to ensure a woman gets a full choice

Q Can EC be offered if there has been any risk more than 120 hours before?

A If there have been multiple episodes of unprotected sexual intercourse (UPSI) or a long delay before presentation, it is possible to offer the fitting of a copper intrauterine device up to the earliest date an implantation could take place. This means there is always at least five days from the first UPSI, and often a lot longer. If a woman usually has a 28 day cycle, an intrauterine device can be fitted up to day 19 regardless of the number of episodes of UPSI in the cycle. If her cycle is longer or shorter, adjustments can be made accordingly. These calculations can be made in good faith from the available cycle length and last menstrual period, but the shortest cycle length should always be used. This will restrict the availability for some women but ensures an intrauterine device is not fitted when there may be an implanted pregnancy.

TABLE 1: EMERGENCY CONTRACEPTION CHOICES AT A GLANCE

	Levonorgesterel	Ulipristal	Copper intrauterine device
How long after UPSI can it be used?	Licenced up to 3 days May have some effect up to 4 days	Up to 5 days	Up to 5 days and longer if still within 5 days after ovulation
How effective is it?	Somewhat Only works up to beginning of LH surge so not during highest risk days of cycle	Reasonably Works up to just before LH peak so not during part of the highest risk days of cycle	Very Works throughout risk time
Eligibility criteria	No medical restrictions to use Affected by enzyme inducing drugs	Asthma not controlled by glucocorticoids Hepatic dysfunction Affected by enzyme inducing drugs	Same as for long term use intrauterine device except for menorrhagia
When should pregnancy test be done?	If next period is delayed by a week or more than three weeks after taking it	If next period is delayed by a week or more than three weeks after taking it	If next period is delayed by a week or more than three weeks after having it inserted

Q What follow up is necessary?

A A pregnancy test is needed if the next expected bleed is a week late or if no bleeding has occurred within three weeks of using EC. It is not uncommon to get some irregular bleeding within the month after taking EC. If there is any doubt that the bleed was not normal and especially if it was lighter than expected, a pregnancy test should be carried out. This can be done either by the patient or healthcare professional, but a reliable product should be used for testing.

Summary

There are three methods available in the UK. The intrauterine device is the most effective, though it also involves the most clinical intervention. All women should be given enough information to choose between the easiest available (but least effective), levonorgesterel, ulipristal, which is more effective but which currently (although hopefully not for much longer) is still limited by prescription, or the most effective, which involves fitting (copper intrauterine device). All professionals should have effective referral pathways to ensure a woman gets a full choice.

Q Should STI risk assessment be carried out every time?

A Each time there has been UPSI the possibility of acquiring an STI must be considered. Taking a sexual history is the mainstay of this assessment and testing should be offered if appropriate. Depending on what infection is being tested for and what test is used, there may be a delay in a test becoming positive of between two weeks and three months.

References

1. Faculty of Sexual and Reproductive Health. Clinical guidance Quick starting contraception. 2010 http://www.fsrh.org/pdfs/CEUGuidanceQuickStartingContraception.pdf accessed 22/1/2015
2. Glasier A, Cameron ST, Blithe D *et al*. *Contraception* 2011, 84; 363-367

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