Emergency contraception

Emergency contraception consultations are sometimes regarded a bit like ‘pill checks’ – a quickie, a potential catch-up slot, possibly can be dealt with on the telephone.

Yet a request for emergency contraception can be a signal that contraceptive and sexual health needs are not being met. We should assess pregnancy risk, and discuss with the patient which of the three emergency contraceptive options is most appropriate and effective. The FSRH has updated its guideline on emergency contraception, and includes some recent changes in best practice (FSRH Emergency contraception, 2017).

Emergency contraception statistics

- 7% of women of childbearing age use emergency contraception each year (ONS Opinions Survey Report 80/09).

In an emergency contraception consultation...

- Assess pregnancy risk.
- Consider medical/drug history.
- Counsel and offer an appropriate emergency contraception method.
- Discuss ongoing contraceptive needs (consider quick starting).
- Advise use of barrier methods/abstinence until protected.
- Assess STI risk and arrange testing.
- Discuss need to perform a pregnancy test ≥3w after unprotected sexual intercourse (UPSI) if an entirely normal period does not occur.
- If a copper intrauterine device (Cu-IUD) cannot be fitted immediately, give oral emergency contraception (in case insertion never happens).

Risk of pregnancy

Based on available data: If 1000 women had a single episode of unprotected intercourse, we might expect:

- 1 unintended pregnancy if a Cu-IUD is inserted postcoitally.
- 5 unintended pregnancies with ulipristal.
- 10 unintended pregnancies with levonorgestrel.
- 110 unintended pregnancies if NO emergency contraception is used.

So, when should we offer emergency contraception after UPSI?

- At any point in a natural menstrual cycle (conception is theoretically possible on most days: risk is highest during the 6 days up to and including ovulation).
- From day 21 postpartum (unless <6m postnatal, fully breastfeeding and amenorrhoeic).
- From day 5 post-miscarriage/abortion/ectopic pregnancy/uterine evacuation for gestational trophoblastic disease).
- Inconsistent or compromised contraceptive use, e.g. missed pills.

The three types of emergency contraception
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| copper IUD (Cu-IUD) | Up to 120h after UPSI or 5d after ovulation (whichever is longer) | **How does it work?** Prevents fertilisation and implantation (if required). **Contraindications/cautions** - Current symptomatic STI is UKMEC 4 (absolute contraindication for IUD insertion). However, in the context of emergency contraception, we have to weigh up the risk of PID against pregnancy risk. So the FSHH advises:  
  - Asymptomatic patient at LOW risk of STI: does not require swabs.  
  - Asymptomatic patient at HIGH risk of STI: fit an IUD and do STI swabs at the same time. Consider giving antibiotic cover if very high risk (e.g. partner has STI). Follow-up and treat appropriately.  
  - Asymptomatic patient with an STI (e.g. has tested positive for chlamydia on a recent swab but has no symptoms): offer to fit an emergency IUD with antibiotic cover (UKMEC 3).  
  - Symptomatic patient at HIGH risk of STI: if at high risk of pregnancy, consider fitting IUD with antibiotic cover for chlamydia (and gonorrhoea if local prevalence or individual risk factors warrant it). Swab at procedure and follow-up appropriately.  
  - <28d postnatal is UKMEC 3 due to risk of perforation.  
  - Risk of implanted pregnancy (UPS <120h ago and >5d after ovulation). **Risks**  
  - 1/1000 uterine perforation.  
  - 1/20 expulsion.  
  - 1/1000 risk of PID. |
| levonorgestrel 1.5mg (ellaOne) | Up to 72h after UPSI (licensed) | **How does it work?** Prevents or delays ovulation up to and including LH surge. Ovulation is delayed for at least 5d which is the lifespan of sperm in the female genital tract. **Contraindications/cautions**  
  - Avoid in severe asthma or asthma not controlled by ICS.  
  - ellaOne contains lactose.  
  - Efficacy may be reduced if BMI >26 or weight >70kg. Give 3mg dose or use ellaOne (it is unknown which is more effective).  
  - If taking an enzyme inducer and declines IUD, give 3mg as a single dose (off licence). **Risks**  
  - No serious adverse events reported.  
  - No evidence of teratogenesis or harm if given in early pregnancy. |

*The IUS should NOT be used as an emergency contraceptive.*

**First-line choice: Cu-IUD**

The Cu-IUD is the gold standard method and should be offered to all women if appropriate. It:

- Is highly effective.
Is the only method which is effective post-ovulation.
- Is unaffected by body weight.
- Is unaffected by enzyme-inducing drugs.
- Provides ongoing contraception if required.

A prospective cohort study looked at the efficacy of the Cu-IUD as emergency contraception. Women attending family planning clinics in China were offered a Cu-IUD and followed up for a year. A total of 1963 women enrolled. Of the 1893 women who attended the first follow-up 1m after insertion, none of them were pregnant (BJOG 2010;117:1205). A Cochrane review identified a failure rate of 0.09% for the Cu-IUD when used for emergency contraception in non-randomised studies (Cochrane 2008;CD001324).

Some women may have cultural/religious reasons for wishing to avoid a method which has a post-fertilisation effect. This should be explained fully to the patient during counselling.

**Second-line choice: oral emergency contraception**

If a woman declines or is not suitable for a Cu-IUD, offer oral emergency contraception as soon as possible.

Oral emergency contraception:
- May be prescribed if UPSI has occurred previously in the cycle.
- May be prescribed more than once in a cycle.
- If given after ovulation, is unlikely to prevent pregnancy.
- Should not be given >120h after last UPSI.

**The evidence**

There are two primary RCTs that have compared ulipristal and levonorgestrel head-to-head. They have demonstrated that ulipristal is at least as good as levonorgestrel, but were not powered to detect superiority (Lancet 2010;375:555). These two studies were then combined in a small meta-analysis. This was able to demonstrate slight superiority of ulipristal over levonorgestrel (Lancet 2010;375:555). However, the confidence intervals were very wide because of the small size of the meta-analysis.

**Which one is best?**

The FSRH considers ulipristal to be the stronger anti-ovulant, and likely to be the more effective agent – especially around ovulation. However, you can’t quick start long-term contraception immediately after giving ulipristal and it does have some interactions.

So, you have to assess the relative merits of each agent in preventing a potential pregnancy from recent activity, while considering the benefits of getting the patient on regular contraception immediately, thereby preventing pregnancy in the near future…

Remember that giving oral emergency contraception is unlikely to do harm. However, giving ulipristal to someone asthmatic on oral steroids may worsen their asthma so should be avoided.

Based on FSRH recommendations, the flowchart below may help you!
Oral emergency contraception and body weight

There has been some conflicting data regarding the effect of raised BMI on the efficacy of oral emergency contraception. A review by the European Medicines Agency in 2014 was inconclusive. In light of this, the MHRA concluded that oral hormonal emergency contraception can be used in all women, regardless of BMI (Drug Safety Update 2014;8(1):A1).

However, the FSRH has reviewed the evidence, including more recent studies, and has concluded that:

- Ulipristal may be less effective in women with BMI >30 or weight >85kg, but there is no evidence that an increased dose is more effective in these women.
- Levonorgestrel may be less effective in women with BMI >26 or weight >70kg.
- The effectiveness of a double dose (3mg) of levonorgestrel is unknown, but it is a safe, well-tolerated drug supported by pharmacokinetic data.

The FSRH advises that in a woman with a BMI >26 or >70kg:

**Offer a Cu-IUD first line, ulipristal second line and, if neither of these are suitable or acceptable, give 3mg levonorgestrel.**

Emergency contraception and drug interactions

Enzyme-inducing drugs

The metabolism of ulipristal and levonorgestrel are increased by enzyme-inducing drugs, so potentially could reduce efficacy. The efficacy of 3mg levonorgestrel in women on enzyme-inducers has not been studied, but the FSRH recommends in women taking enzyme-inducing drugs:

**Offer a Cu-IUD first line, and, if this is not suitable or unacceptable, offer 3mg levonorgestrel (this is off licence).**
Note: if emergency contraception is prescribed at the same time as post-exposure prophylaxis for sexual exposure to HIV (PEPSE), check for interactions. The current BASHH recommended regime contains Truvada and raltegravir, which are not enzyme-inducers.

Ulipristal and progestogens

A study has shown that desogestrel given immediately after ulipristal reduces its efficacy. While it is unknown whether this is a class effect, the FSRH recommends:

- Do not give any progestogen-containing medications for 5d after giving ulipristal.
- Do not give ulipristal if any progestogen-containing medications have been taken in the past 7d.

(See article on Drug interactions and hormonal contraception for more information on drug interactions.)

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**Emergency contraception**

- The Cu-IUD is the most effective form of emergency contraception, and provides ongoing contraception. It should be offered first line.
- Oral emergency contraception should be offered second line, and should be taken as soon as possible after UPSI.
- Ulipristal can be used up to 120h after UPSI. It is likely to be more effective than levonorgestrel.
- Levonorgestrel can be used up to 72h after UPSI and up to 96h off licence.
- Give ulipristal in women with a raised BMI.
- In women on enzyme-inducers, offer a double dose (3mg) of levonorgestrel.
- Discuss ongoing contraception and offer quick starting if appropriate.

- Does your practice have the facility to provide emergency IUD fitting?
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