Quick-starting contraception

Accidental contraceptive use in pregnancy

Traditionally, contraception has always been started on the first day of menstruation to guarantee that a woman is not pregnant, and therefore preventing a foetus from being exposed to artificial hormones. In nearly 50 years of hormonal contraception, teratogenesis has not been observed in accidental exposure during pregnancy. It is estimated that around 70,000 foetuses per year in the US are exposed to oral contraceptives.

What is quick-starting?

Quick-starting contraception is the initiation of a method of contraception without waiting for the next period, or after giving emergency contraception; this may mean that there exists a small risk of pregnancy. It is an unlicensed but endorsed practice by the FSRH (FSRH Quick-starting contraception 2010).

When is a woman not pregnant?

According to the FSRH, a health professional can be 'reasonably certain' that a woman is not pregnant (FSRH UK Selected Practice Recommendations for Contraceptive Use 2002):

- If she has not had sexual intercourse since her last period.
- If she is on day 1–7 of a normal 28d menstrual cycle.
- If she is <4w post-natal.
- If she is <7d post TOP or miscarriage.
- If she has been correctly and consistently using a reliable method of contraception.
- If she is fully or nearly fully breast-feeding, amenorrhoeic and <6m post-partum.
- If she has not had unprotected sexual intercourse in the past 3w and a pregnancy test is negative.

Why quick-start?

Potential benefits are:

- Reduced pregnancy risk as reliable method is started immediately.
- Fewer barriers for patient – no need to come back for a further visit in the short-term.
- Reduced cost to NHS and patient in terms of further clinic visits/time.
- Patient will be more motivated to start and continue method if begun immediately.

It makes perfect sense!

However, the evidence base is pretty weak. A Cochrane review (2012;CD006260) concluded that there is little evidence that immediate start reduces unintended pregnancies or improves continuation rates. Only one study showed lower risk of pregnancy, and that was with Depot-Provera. Side-effects and bleeding patterns were similar in immediate and conventional start groups. The authors concluded that more research is needed.

The FSRH states that, while there is a paucity of evidence demonstrating effectiveness, there is data suggesting women find quick-starting acceptable.

What are the problems of quick-starting?

Pregnancy! Diagnosis may be delayed because amenorrhoea is wrongly attributed to the contraception. Although the data regarding risk is reassuring, a woman may be psychologically affected by the knowledge that her baby was exposed to hormones in utero.

An observational study suggested depot use in early pregnancy was linked with increased risk of low birth weight and neonatal death. This may have been due to confounding factors, and follow-up of the same group showed no long-term adverse growth or development (Paediatr Perinat Epidemiol 1990;4:184).

Counselling patients

Because of the risk of pregnancy and the use of a medicine off-licence, careful counselling is essential when quick-starting. Explain:

- Quick-starting is an off-licence but endorsed practice which is considered safe by leading experts on contraception and the WHO.
- Extra precautions will be needed until the method becomes effective.
- She must do a pregnancy test 3w after last UPSI. If the pregnancy test is positive, she should stop the method as soon as
possible and return to the clinic for further advice. Reassure her that there is no evidence that the hormones will harm a baby. Document your discussion and that the patient understands and has expressed a preference to begin contraception as soon as possible.

What methods can be quick-started?

<table>
<thead>
<tr>
<th>Method</th>
<th>Extra precautions</th>
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<tbody>
<tr>
<td>Combined hormonal contraception</td>
<td></td>
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<tr>
<td>(except Dianette/Yasmin – see below)</td>
<td></td>
</tr>
<tr>
<td>Olaira</td>
<td>9d</td>
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<tr>
<td>Progesterone-only pill</td>
<td>2d</td>
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<tr>
<td>Subdermal implant</td>
<td>7d</td>
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<tr>
<td>Progesterone-only injectables (depot) **</td>
<td>7d</td>
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</tbody>
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**PLEASE NOTE:** while progesterone-only injectables can be quick-started if desired or appropriate, the drawbacks are that, in the event of pregnancy, the hormone cannot be removed and exposure will continue for the duration of the injection. While there is no evidence this is harmful, it may be better to counsel the patient to ‘bridge’ with a pill until pregnancy has been excluded.

What methods can NOT be quick-started?

- Copper IUD (UNLESS being fitted as emergency contraception; copper IUDs cannot be quick-started because they can induce an abortion if an established embryo is present).
- IUS should never be fitted as emergency contraception and should not be quick-started for the same reasons as the copper IUD. Additionally, there may be risks to a foetus from the high localised concentrations of levonorgestrel (although no cases of pregnancies with an IUS in situ have been associated with birth defects to date).
- Co-cyprindiol (Dianette) contains cyproterone which is anti-androgenic and so potentially could feminise a male foetus. Although there has been no evidence of harm to foetuses, co-cyprindiol is not licensed as a contraceptive so should be avoided in quick-starting. Yasmin also contains an anti-androgenic progestogen so should be avoided.

Ulipristal (ellaOne) and quick-starting

As ulipristal (ellaOne) is a progesterone receptor modulator, there have been theoretical concerns regarding its interaction with other hormonal contraception. Two recent studies have examined this question.

One found that ulipristal does not appear to affect the efficacy of the COC at inhibiting ovulation (Hum Reprod 2015;30:1566).

The other study found that ulipristal does not appear to affect the efficacy of the desogestrel POP at inhibiting ovulation and impairing cervical mucus penetrability (Hum Repro 2015; doi:10.1093/humrep/dev241 [Advance Access published September 23, 2015]). But it did find that the desogestrel POP does affect the efficacy of ulipristal at inhibiting ovulation.

These studies are very small, only include the contraceptive pills, and do not examine pregnancy as an end-point. However, in the absence of other data, the FSRH (CEU Statement on quick-starting after UPA, September 2015) has recommended the following.

After giving ulipristal for emergency contraception, we advise a woman to:

- Not start a hormonal method of contraception for at least 5d.
- Use barrier methods or abstain from sex until effective contraceptive cover has been achieved.
- Take the usual recommended contraceptive precautions according to method chosen after these 5d (see table above).

Bridging methods

Bridging methods of contraception are short-term methods which are quick-started and continued until a suitable time is available (or pregnancy has been excluded), when a preferred long-term method can be initiated.

The same methods that can be quick-started can be used as bridging methods, with the same advice on extra precautions.
Quick-starting and bridging

- Quick-starting is the initiation of a method of contraception without waiting for a next period.
- This is an FSRH-endorsed practice which may reduce further pregnancy risk by establishing a reliable method of contraception.
- Because it is unlicensed and there may be a potential risk of pregnancy, careful counselling is necessary.
- The progesterone-only pill, the subdermal implant, combined hormonal preparations and depot can all be quick-started.
- IUD can only be quick-started when used as emergency contraception.
- IUS, Dianette and Yasmin should not be quick-started.
- Do not quick-start after giving ulipristal (ellaOne). Start contraception after 5d with usual advice on extra precautions.
- Bridging is when a short-term contraceptive measure is quick-started to cover the patient until a preferred long-acting method can be initiated.