

Emergency Contraception

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What is emergency contraception?

Emergency contraception (E.C) is also known as post-coital pill (PCC) or 'the morning after pill'. It is the provision of preventing the establishment of a pregnancy following either an unprotected sexual intercourse or a potential contraceptive failure (1). Patients presenting to a general practitioner asking for emergency contraception should be seen and treated the same day. All the reception staff working in a surgery should be trained and patient requesting a PCC over the phone should be fitted in the surgery the same day. Teenage pregnancy is a public health priority (2) and government targets have been set to half the rate of conceptions in people under the age of 18 years in England by 2010 (3). Most people begin to consider sexual activity in adolescence (4). This is a period of psychological maturation. The UK has a higher teenage birth rate in Western Europe (5). About 90,000 teenagers in England become pregnant, resulting in 56,000 live births. Of these 2,200 are to girls aged 14 or under and 7,700 are to under 16 years age. There is a need to improve the provision of emergency contraception (6), but access to the service within 72 hours can be difficult for young girls who may be worried about the confidentiality (2).

WHEN NEEDED

Emergency contraception is needed either because of split or slipped dures or a potential contraceptive failure e.g. late starter of the contraceptive pill on top of usual seven day break, forgetting to take the pill because of excessive alcohol intake or not taking precautions if vomiting/diarrhoea or antibiotic usage. Missing more than one pill in the first week of the pack could be another reason. Young women for whom sexual intercourse is often unpremeditated and therefore unprotected represents one of the most important groups requiring emergency contraception (7).

HISTORY

Before issuing a prescription, an accurate history to assess the risk of a pregnancy and whether an emergency contraception is needed must be taken (2). There may be a significant age difference between the patient and the partner or there could be an issue of abuse. General practitioner must have an access to

local and national child protection guidelines. An accurate history of last menstrual period, usual cycle, date and time of last unprotected sexual intercourse and whether she has had other episodes of UPSI during that cycle should be recorded. History of current medication—enzyme inducing drugs e.g. antiepileptics, St John's wort which could reduce the efficacy of E.C. should be taken. The only absolute contraindications are pregnancy or a history of serious allergy to any ingredient of the medication. Acute intermittent porphyria, severe liver disease, venous thromboembolism on anticoagulants, breast cancer is some of the relative contraindications.

EXAMINATION

Physical examination should include measurement of height, weight, and blood pressure. A routine urine check for protein & sugar should be done. Advice and help regarding smoking, alcohol and drugs should be given if needed. A pelvic examination is only necessary if an infection is suspected or if the IUCD method is used.

TREATMENT

Two methods are available in the UK-

1) Hormonal method. This contains 1.5 mg of Levonorgestrel (LNS) and is given as a single dose as soon as possible after an UPSI. This is available on the prescription as Levonelle 1500 or as purchase by women over sixteen at pharmacies as Levonelle One Step, both by Schering Health UK. Only those pharmacists who have undertaken training and signed Patient Group Direction (PGD) can dispense the pill.

The sooner it is taken, the greater the efficacy

0 - 24 hours	95% efficacy
25 - 48 hours	85% efficacy
49 - 72 hours	58% efficacy

It is licensed to be prescribed within 72 hours of UPSI, although it is known to have some efficacy for up to 120 hours but effectiveness decreases the longer the delay. It acts by interrupting the follicular development and ovulation. There is no effect on implantation. Side effects with E.C are rare.

Nausea is reported in 15% of cases and vomiting in 1-2 % cases. If vomiting occurs within two hours of taking the pill, the patient should return for a repeat dose of Levonelle 1500(1). Irregularity of cycle is another side effect. 50% of women reported bleeding a few days earlier or later than expected and 16% had bleeding unrelated to menses within the next seven days (8). Cramps, headaches, dizziness and breast tenderness could be some other side effects. Because this is a progestogen, the oestrogen related cardiovascular risks are not a concern.

2) Copper containing IUCD (not Mirena). This is more effective and prevents nearly 100 % of pregnancies. It has both pre and post ovulation effects. The toxicity of copper prevents fertilisation. If inserted later in the cycle, it causes an inflammatory reaction in the endometrium; preventing implantation (9). It can be inserted within five days (120 hours) after UPSI. If intercourse has occurred more than five days previously, an IUCD can still be inserted up to five days after the earliest likely calculated ovulation. Before inserting the coil a pelvic examination and swabs should be taken to exclude sexually transmitted diseases. If patient is at a risk, treatment with 1 Gm, Azithromycin should be given. Absolute contraindications to the coil insertion are few and same as to the routine use of coil. This is a better option if patient is taking enzyme inducing drugs such as antiepileptic or St John's wort.

FOLLOW UP

All patients should be followed up in three or four week time after prescribing a PCC or the coil insertion.

No emergency contraception is 100% effective. Pregnancy should be excluded by doing a pregnancy test if period is late by one week or more. If patient is pregnant various options regarding termination/continuation/adoption should be discussed. Regular methods of contraception should be discussed and advice should be given regarding safe sex. If indicated screening for STD should be done. A general practitioner can do a lot to reduce the burden of STI. Chlamydia screening in England varies from area to area. One can visit

www.chlamydia-screening.nhs.uk to find out what is happening in one's practice area. NICE and the national Collaborating Centre for women and children's health have produced a guideline recommending that Long Acting Reversible Contraception (LARC) should be offered to all women as part of their contraceptive choices after emergency contraception.

CONCLUSION

There is an increased awareness of emergency contraception although the confusion exists particularly among those aged 16-20 years regarding the time limit for its effectiveness. Every GP practice should have a practitioner with an interest in family planning and sexual health or a family planning trained nurse.

COMPETING INTERESTS

None Declared

AUTHOR DETAILS

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