EMERGENCY CONTRACEPTION FOR ICGP 2020

“POST COITAL CONTRACEPTION”

“The morning After Pill”
The traditional “Yuzpe” method using COC now obsolete in Ireland

We now use either:

1. LEVONORGESTREL (Progestagen only tablets) egg. “Prevonelle” & “Norlevo”

2. The most recent & most effective hormonal option; ulipristal acetate (“ellaOne”)

3. The most effective Copper Coil
ECC GUIDELINES UPDATED
MARCH 2017
LEVONORGESTREL (LNG)

“Norlevo” & “Prevenelle”

• Both contain 1500 Levonorgestrel (the same artificial progestagen used in COCPs & the IUS range

• Works primarily by delaying expected date of ovulation but mechanism unclear—recent FSRH document says non effective after LH surge
SIDE EFFECTS

Rarely reported but literature includes:

- Nausea
- Bleeding
- Breast Tenderness
- Dizziness
- Fatigue
- Headache
- Abdominal Pain

All of which are MUCH less common with Progestagen -Only regimen as compared with Oestrogen + Progestagen

Irregularity in bleeding pattern is the commonest side effect. Patients who take ECP before mid cycle often experience a “withdrawal” bleed during the next week. It may be heavy and/or long. If so their next actual menstrual bleed may be lighter.

As any deviation from the norm can unsettle the patients and increase their worries about pregnancy a good motto is any bleed is probably good news, no bleeding isn’t necessarily bad news but come back within the next 3 weeks for a review to be sure!
EFFICACY OF LEVONORGESTREL

• If taken within 24 hrs prevents up to 95% of pregnancies expected to occur if no EC had been used

• If taken within 24-48 hrs up to 85% effective

• If taken 48-72 hrs after UPSI or assault prevents up to 58%

• If taken 96 hrs after UPSI; no firm data but now thought to be ineffective
EFFICACY OF LEVONORGESTREL

• Failures possible, rates vary depending on where in cycle exposure occurred and how long it took to obtain ECP.
• Absolutely no connection shown between failure and congenital defects.
• No evidence to support concern that failures experience higher rates of Ectopic pregnancy

• WEIGHT & efficacy concerns
In 2013 HRA Pharma changes SmPC to include “data” that questions the efficacy of Norlevo in women over 75 kg.

They based this on their own study (funded by HRA Pharma) published in 2011 in "Contraception". This was an “Inferiority Study” powered to prove UA was not inferior in efficacy to LNG. In this trial 1696 women from the UK & US were recruited and randomised into LNG (852) or UA (844) (single blind).

There were 22 pregnancies in the LNG group & 15 pregnancies in the UA group.

The FSRH advised (Nov 2013): this data was gathered by the pharma itself and does not warrant any dispensing/prescribing changes.

They supported the use of all 3 methods in slim & obese women alike but suggest DOUBLING DOSE of LNG in women >70kg
ULIPRISTAL ACETATE

• “ellaOne”
• Selective Progesterone Receptor Modulator (SPRM)
• 30mg single dose
• 3x more expensive (\(? \) € 35)
• Made by HRA Pharma who also produce ‘Norlevo’
• Now OTC
‘ELLAONE’

- Ulipristal SPRM related to the original SPRM Mifepristone (‘Ulipristal is a second generation SPRM’)
- 2 RCTs showed it to be as good as Levonorgestrel within 24 hrs but pooled data showed superior efficacy >24 hrs & up to 120 hrs
- Unpublished meta analysis showed superior efficacy in OW or Obese patients
- Side Effects incl Menstrual type Cramping
- C/I in Breastfeeding, Severe asthma/liver impairment
- Precautions with LEI meds & concurrent Progestagen containing Contraceptives
MARCH 2017 CHANGES TO ELLAONE RX

• No longer limited to a single Rx per cycle
• GORD restrictions lifted but still not suitable for asthmatics on steroids
• Breast feeding still a problem – for 7 days
• Must avoid hormonal contraception where possible for 5 days after taking UPA to allow sperm to die
• May be impaired if hormonal contraception used in the previous 7 days
• Cannot be offered to women on LEIs as there is limited data on the use of double dose UPA
PROGESTAGEN CONTAINING CONTRACEPTION MAY UNDERMINE EFFICACY OF ELLAONE & ELLAONE MAY UNDERMINE THE CURRENT PROGESTAGEN CONTAINING CONTRACEPTIVE!
***(RE) STARTING HORMONES AFTER ELLAONE***

<table>
<thead>
<tr>
<th>UPA = day 0</th>
<th>Methods (day UPA+5)</th>
<th>Requirement for additional contraception</th>
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<tbody>
<tr>
<td></td>
<td>Combined oral contraceptive pill (except Qlaira®)</td>
<td>7 days</td>
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<tr>
<td></td>
<td>Qlaira®) Combined oral contraceptive pill</td>
<td>9 days</td>
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<tr>
<td>UPA then wait at least 5 days</td>
<td>Combined vaginal ring/transdermal patch</td>
<td>7 days</td>
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<tr>
<td></td>
<td>Progestogen-only pill (traditional/ desogestrel)</td>
<td>2 days</td>
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<tr>
<td></td>
<td>Progestogen-only implant or injectable</td>
<td>7 days</td>
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MODES OF ACTION COMPARED

• LEVONORGESTREL
  • Not fully understood
  • May inhibit ovulation
    • Unlikely to inhibit implantation
  • Essentially useless after ovulation

• ULIPRISTAL
  • ↓ Follicle growth
  • ↓ LH surge blocking
  • Follicle Rupture
  • Delays Endometrial maturation & induces early Endom Bleeding but still prob useless after ovulation
FSRH INFO ON EC ACTION
FOLLOW UP

• Arrange review to confirm success, discuss long term contraception, out rule infection

• Removal of IUCD if indicated
• Pregnancy test if indicated
POST COITAL IU COPPER COIL

• Less commonly employed but extremely effective and reliable method of post coital contraception
• Commonly offered in UK FP clinics
• Must be very familiar & comfortable with Coil insertion
• CAN NOT USE MIRENA (must have Cu)
POST COITAL EMERGENCY IUCD

• Insertion of a Cu IUD within 5 days of exposure has an even higher efficacy than oral progestagen, however...

• Not all doctors are familiar with the technique.
• It CAN be painful particularly for nulliparous women
• It enables the passage of any infective organisms that may have deposited into the vagina through to the uterine cavity thus increasing the likelihood of STI following sexual assault
• It may be unsuitable to leave the device inside the patient beyond her next menstrual bleed so will require her to return for removal procedure.

...a viable option and should be considered in rare circumstances where ECP isn’t ideal or even in conjunction with Levonorgestrel depending on circumstances.
HOW TO DECIDE WHICH METHOD?

Ask:
When was the LMP or withdrawal bleed?
Could she already be pregnant?
Timing of episode(s) of UPSI: how much risk is there?
Potential drug interactions; any Rx meds, St John’s wort, GORD, steroids?
Medical eligibility criteria

Offer:
information on all available methods
Focus on future contraception
Mention STI screening