Emergency contraception care

Advise for recent changes in the practice environment

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- Does levonorgestrel work better than estrogen-progestin combination in preventing pregnancy?
- Which method is better tolerated, levonorgestrel or estrogen-progestin?
- When should emergency contraception be initiated?
- How often can emergency contraception be used?

This guideline targets women who have had unprotected or inadequately protected intercourse within the past 120 hours and do not desire pregnancy.

Practitioners can make informed decisions about obstetric and gynecologic care, given the evidence in this guideline regarding safety, efficacy, risks and benefits of the use of emergency contraception including progestin-only and combined estrogen-progestin regimen.

The major outcome considered was incidence of unintended pregnancy. The evidence rating is updated to comply with the SORT taxonomy.[1]

Guideline relevance and limitations

This guideline is extremely relevant in light of the recent decision (August 2006) by the US Food and Drug Administration to allow the Plan B (levonorgestrel) to be sold over the counter to women aged 18 and older.[2] It is still available by prescription to women aged <18 years.

Forty-nine percent of pregnancies were unintended in 2001. Of these 3.1 million unintended pregnancies, only 44% ended in births.[3] Emergency contraception has an important role in reducing the number of unwanted pregnancies.

Lack of cost analysis weakened this guideline. Emergency contraceptive doses for commonly prescribed oral contraceptives are listed in the **TABLE**.

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Guideline development and evidence review

A search of the literature was performed using Medline, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents. Restrictions included articles published in English between January 1985 and January 2005. Priority was given to meta-analyses and systematic reviews, which were analyzed by an expert panel. Recommendations were graded. Abstracts of research presented at conferences and symposiums were not considered adequate to be considered.

Source for this guideline

American College of Obstetricians and Gynecologists (ACOG). Emergency contraception. ACOG practice bulletin no 69. Washington, DC: American College of

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Practice recommendations

GRADE A RECOMMENDATIONS

- Emergency contraception should be made available to women who have had unprotected or inadequately protected sexual intercourse and who do not desire pregnancy.
- The levonorgestrel-only regime is more effective and is associated with less nausea and vomiting. It should be used in preference to the combined estrogen-progestin regimen.
- The 1.5-mg levonorgestrel-only regimen can be taken in a single dose.
- The two 0.75-mg doses of the levonorgestrel-only regimen are equally effective if taken 12 to 24 hours apart.
- To reduce the chance of nausea with the combined estrogen-progestin regimen, an antiemetic agent may be taken 1 hour prior to the first emergency contraception dose.
- Prescription or provision of emergency contraception in advance of need can increase availability and use.

GRADE B RECOMMENDATIONS

- Treatment with emergency contraception should be initialized as soon as possible after unprotected or inadequately protected intercourse to maximize efficacy.
- Emergency contraception should be made available to patients who request it up to 120 hours after unprotected intercourse.
- No clinician examination or pregnancy testing is necessary before provision or prescription of emergency contraception.

GRADE C RECOMMENDATIONS

- No data specifically examined the risk of using hormonal methods of emergency contraception among women with contraindications to the use of conventional oral contraceptive preparations; nevertheless, emergency contraception may be made available to such women.
- Clinical evaluation is indicated for women who have used emergency contraception if menses are delayed by a week or more after the expected time, if lower abdominal pain occurs, or persistent irregular bleeding develops.
- Information regarding effective contraceptive methods should be made available either at the time emergency contraception is prescribed or at some convenient time thereafter.
- Emergency contraception may be used even if the woman has used it before, even within the same menstrual cycle.

FAST TRACK

Emergency contraception may be offered even to women unable to use conventional OCs

Obstetricians and Gynecologists (ACOG); 2005. 10 p. [86 references]

Other guidelines

Emergency Contraception

This 2005 guideline published by the American Academy of Pediatrics is similar to the ACOG Guideline. It is comprehensive, but recommendations are not graded. The focus is on adolescent use of emergency contraception. It has an excellent section on telephone triage of sexually active teens prior to prescribing emergency contraception.

Source. American Academy of Pediatrics. Emergency contraception. *Pediatrics* 2005 Oct;116(4):1026-35. [101 references] Available at: aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1026.

Emergency Contraception

This 2003 Scottish guideline is well written, but lacks information about all current options for emergency contraception. It is strengthened by cost-effectiveness analysis.

Source. Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Emergency contraception. Aberdeen, Scotland: Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit; 2003 Jun. 7 p. [53 references] Available at: www.ffprhc.org.uk/admin/uploads/EC%20revised%20PDF%2019.06.03.pdf.

Contraception and Family Planning: A guide to counseling and management

This 2005 guideline was published by Brigham and Women's Hospital in Boston.

TABLE

Emergency contraception dosage for commonly prescribed oral contraceptives

BRAND NAME	ETHINYL ESTRADIOL PER DOSE (MCG)	LEVONORGESTREL PER DOSE (MG)	FIRST DOSE	SECOND DOSE (12 HOURS LATER)
Progestin only				
Plan B	0	1.5	2 white pills	none
Ovrette	0	1.5	20 yellow pills	20 yellow pills
Combined progestin/estrogen pills				
Alesse	100	0.50	5 pink pills	5 pink pills
Lo/Ovral	120	0.60	4 white pills	4 white pills
Ovral	100	0.50	2 white pills	2 white pills
Seasonale	120	0.60	4 pink pills	4 pink pills
Triphasil	120	0.50	4 yellow pills	4 yellow pills

Source: adapted from Office of Population Research at Princeton University.[4]

In addition to emergency contraception, it provides recommendations on hormonal contraception (oral contraceptive pills, depo-medroxyprogesterone acetate, estrogen-progestin patches, vaginal ring, and levonorgestrel intrauterine), barrier contraception, intrauterine devices, surgical methods for contraception, and pregnancy termination.

Source. New Brigham and Women's Hospital. Contraception and family planning. A guide to counseling and management. Boston, Mass: Brigham and Women's Hospital; 2005. 15 p. [6 references]. Available at: www.brighamandwomens.org/medical/handbookarticles/ContraceptionGuide.pdf.

REFERENCES

1. Ebell M, Siwek J, Weiss BD, et al. Strength of recommendation taxonomy (SORT): A patient-centered approach to grading evidence in the medical literature. *J Fam Pract* 2004; 53:111–120.
2. US Food and Drug Administration. FDA approves over-the-counter access for Plan B for women 18 and older-prescription remains required for those 17 and under. *FDA News,* August 24, 2006. Available at: www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html. Accessed on November 13, 2006.
3. Finn LB, et al. Disparities in unintentional pregnancy in the United States, 1994 and 2001. *Perspect Sexual Reprod Health* 2006; 38:90–96.
4. The Emergency Contraception Website. Office of Population Research at Princeton University and the Association of Reproductive Health Professionals. 2006. Available at: ec.princeton.edu/questions/dose.html. Accessed on November 13, 2006.

FAST TRACK

"Plan B" is approved for OTC use; emergency dosages for other preparations appear in the Table