Emergency Contraceptive (EC) – CON 17

DEFINITION

Emergency contraceptive is used after unprotected/under-protected intercourse or known or suspected contraceptive failure to prevent conception and subsequent pregnancy. Methods use to prevent conception after coitus include levonorgestrel pill (Plan B or generic), ulipristal acetate (UPA) pill (ella), combination of ethinyl estradiol and norgestrel or levonorgestrel pills, or copper-releasing IUD. Mechanism of action varies but includes inhibiting or delaying ovulation and may prevent fertilization and interference with implantation. EC will not disrupt an already established implantation or pregnancy due to minimal endometrial effect. EC has no effect on fetal development if a woman is already pregnant.

SUBJECTIVE

Should include:

1. Menstrual history including LMP
2. Obtain history of first episode of unprotected intercourse in cycle to determine if pregnancy test is warranted
3. Obtain history of last episode of unprotected intercourse to ensure patient is within time frame for EC
4. Obstetric history; breastfeeding status
5. Current contraceptive use, method administration/compliance, and reproductive life plan
   - UPA is not preferred ECP method if hormonal contraception was utilized within past 5 days due to decreased efficacy likely to receptor site competition.
6. STI/PID; vaginitis symptoms
7. STI and HIV status/risk factors
8. Medical history to determine acceptability of Cu-IUD method and method contraindications as guided by Medical Eligibility Criteria (MEC) for Contraceptive Use. There are no risks to LNG-ECP use that outweigh the benefits of preventing unintended pregnancy.
   - Drug interactions resulting in reduced efficacy of UPA may occur with hepatic enzyme-inducing drugs and drugs reducing gastric pH; dosage modifications

OBJECTIVE

May include:

1. Vitals, weight and BMI
2. Focus exam, as indicated (i.e., pelvic exam, cervicitis/vaginitis, etc.)
3. Pregnancy test (if history indicates)

Establish reasonable certainty that the patient is not already pregnant. Obtain a pregnancy test with any method, as indicated.

LABORATORY

May include:

1. Sensitive urine pregnancy test

ASSESSMENT

Candidate for ECP

PLAN

1. Treatment option:
   a. Take levonorgestrel pill (Plan B or generic) as soon as able after intercourse and within 120 hours for maximum effectiveness. Medication can be prescribed via prescription or OTC. Levonorgestrel 1.5mg. Take one tablet now (PO), as directed. Any regular contraceptive method can be started immediately

after the use of levonorgestrel or combined estrogen and progestin ECPs. Recommend that women with BMI >30 kg/m2 or women taking enzyme-inducing drugs such as antiseizure medication or certain antiretroviral therapies, take a double dose of LNG-ECP.

b. Take Ulipristal acetate (ella) as soon as able after intercourse and within 120 hours for maximum effectiveness. UPA 30mg. Take one pill now (PO), as directed (prescription only). UPA has been shown to be more effective than the levonorgestrel formulation 3–5 days after unprotected sexual intercourse. Advise the woman to start or resume hormonal contraception no sooner than 5 days after use of UPA and provide or prescribe the regular contraceptive method as needed. Breastfeeding patients should pump and discard breastmilk from infant's feeding supply for 36 hours after administration.
c. Certain combined OC's may be used for emergency contraception. Combined estrogen and progestin in 2 doses (Yuzpe regimen: 1 dose of 100 µg of ethinyl estradiol plus 0.50 mg of levonorgestrel followed by a second dose of 100 µg of ethinyl estradiol plus 0.50 mg of levonorgestrel 12 hours later)
d. The Copper IUD can be inserted within 5 days of the first act of unprotected sexual intercourse as an emergency contraceptive. Efficacy rate is nearly 100%.

2. OTC analgesics may be utilized for side effect profile; most common side effects reported with UPA use are headache and dysmenorrhea with the next cycle.
3. Discuss menstrual cycle tracking with the patient; cycle delay may occur after ECP use. If expected menses is delayed by one week or more, a pregnancy test should be performed and if needed, follow-up with a provider.
4. The use of an antiemetic should be considered with the use of combined pills. Pretreatment with antiemetics may be considered depending on availability and clinical judgment. There are fewer incidences of nausea/vomiting when using the progestin-only formulation. If the patient vomits within 2 hours of taking pills, consider the administration of a repeat dose of progestin ECP and the use of antiemetics.
   a. Options for preventing or treating nausea (for combined pills) include:
      i. Nonprescription drugs (may cause drowsiness):
         - Dimenhydrinate (Dramamine) 50mg tablets. Swallow 1-2 tablets one hour before taking ECP's and repeat every 4-6 hours prn.
         - Diphenhydramine hydrochloride (Benadryl) 25 mg tablets. Swallow 1-2 tablets one hour before taking ECP's and repeat every 4- 6 hours prn.
         - Meclizine hydrochloride (Antivert/Dramamine II) 25mg tablets. Swallow 1- 2 tablets one hour before taking Emergency Contraceptive Pills. Repeat if needed in 24 hours. May cause sedation
      ii. Prescription drugs (do not drive or use dangerous equipment):
         - Zofran 4-8mg. Swallow pills or use rapid dissolving tablets one hour prior to ECP's.
         - Promethazine hydrochloride (Phenergan) 12.5-25mg tablets. Swallow 1 tablet one hour before taking ECP's or insert a 12.5-25mg rectal suppository ½ hour before and every 12 hours prn.
         - Metoclopramide (Reglan) 10 mg one hour before ECP.
5. May provide an advance supply of emergency contraceptive pills.

CLIENT EDUCATION

1. Provide client education handout(s). Review manufacturer's inserts. Review symptoms, complications, and danger signs.
2. Review safer sex education, as appropriate

CONSULT / REFER TO PHYSICIAN

1. Any client who cannot tolerate EC dosing for consideration of other options (i.e., IUD insert, other medication regimens).
2. Positive pregnancy result

REFERENCES

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