South Tyneside Sexual Health

GATESHEAD SEXUAL HEALTH

NHS
South Tyneside and Sunderland
NHS Foundation Trust

Emergency Contraception

PGD training

Pharmacists South Tyneside and Gateshead

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Introduction

- EC is complicated!
- We are passionate about getting it right
- High abortion rates in NE
- Short interpregnancy intervals
- EC is not a contraceptive
- Does not always work
- Need to work together /signpost

Outline

- What do you already know quiz?
- What is emergency contraception (EC)?
- When is EC indicated?
- How does EC work
- Choice
- PGD- including contraindications/cautions
- Safeguarding
- What have you learnt quiz!

What do you already know?

Emergency Contraception

Quiz

Part 1.

Question 1

Jade is 30, she had taken Ulipristal acetate (UPA) on cycle day 11 via her local sexual health clinic. Jade has a regular 28 day cycle. Jade attends her local pharmacy following further episodes of UPSI on cycles days 14, 16 and 17.

Jade can have Ulipristal again?

- True
- False

TRUE

- EC providers can offer a woman UPA-EC or LNG-EC if she has had UPSI earlier in
  the same cycle as well as within the last 5 days, as evidence suggests that UPA-EC and LNG-EC do not disrupt an existing pregnancy and are not associated with fetal abnormality.
- If a woman has already taken UPA-EC once or more in a cycle, EC providers can offer her UPA-EC again after further UPSI in the same cycle.
- If a woman has already taken LNG-EC once or more in a cycle, EC providers can offer her LNG-EC again after further UPSI in the same cycle
- NB (UPSI at very high risk time in her cycle and likely after ovulation where oral EC is ineffective)

Question 2

Donna is 35 and uses Desogestrel (POP) for her contraception. She missed 1 pill and had UPSI 1 day after. She presents 72hrs after the episode of UPSI and wants the most effective EC method. **What would you advise Donna?**

A) EM IUCD

B) 1.5mg Levonogestrel (LNG)

C) 30mg UPA

A

- The FSRH support that the most effective method of emergency contraception is the Copper intrauterine device, which can be fitted up to 120hrs after UPSI or up to 5 days after the earliest estimated date of ovulation

Question 3

Donna declines and IUCD.

You can offer her UPA 30mg?

- True
- False

False

- If a woman has taken progestogen-containing drug within 7 days prior to taking UPA-EC,the effectiveness of UPA-EC may theoretically be reduced, therefore use of LNG-EC rather than UPA-EC can be considered. This is also important when commencing hormonal contraception after UPA. The effectiveness of UPA-EC (but not of LNG-EC) could be reduced by immediate subsequent use of progestogen-containing contraception or drug. Therefore, ongoing hormonal contraception or hormone therapy should not be started until 5 days after UPA-EC administration

Question 4

Laura is 42. She took her POP as normal Friday morning and had UPSI Friday evening. She missed her POP entirely Saturday and Sunday, and restarted when she remembered on Monday morning. **EC is indicated for Laura?**

- True
- False

FALSE

- FSRH – EC may be indicated if there has been a late or missed POP >27 hours since last pill for traditional POP or > 36 hours for desogestrel POP. EC is indicated if a pill is late or missed and there has been UPSI or barrier failure before efficacy has been re-established. Laura had UPSI on the day she took her pill meaning she was covered by that pill and previously taken pills. As Laura had no further UPSI EC in this case would not be required and Laura can be reassured.

Question 5

Lucy is 27 years old, she attends to access oral EC. She had one episode of UPSI approximately 48hrs ago. On history taking Lucy tells you she had a termination of pregnancy 6 days ago.

Lucy is eligible for EC?

- True
- False

False

- FSRH guidance supports the need for EC in those women who have had
  UPSI from Day 5 after abortion, miscarriage, ectopic pregnancy or uterine
  evacuation for gestational trophoblastic disease (GTD)
- **OR**
- UPSI from Day 21 after childbirth (unless the criteria for lactational amenorrhoea are met).
- Lucy had UPSI 4 days after a TOP so EC is not indicated – she can be reassured. It would be worth discussing ongoing contraception with Lucy and signposting her to relevant services.

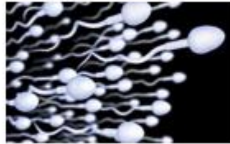
WHAT IS EMERGENCY CONTRACEPTION?

What is emergency contraception?

- Intervention aimed at preventing unintended pregnancy
  - After UPSI / potential contraceptive failure
- EC works to prevent
  - Ovulation (oral EC- UPA/LNG)
  - Fertilisation and/or implantation (Cu-IUD)
- It is intended for occasional use
- Does not replace effective regular contraception
- Is not 100% effective!

Menstrual cycle

SPERM survive 5 days



Ovarian Cycle

Ovulation

Ovum: 24 hours

Luteal Phase

LH Surge

6 days blastocyst --> implantation

FSH

LH

Progesterone

Luteal phase- fixed

Estradiol

Follicular phase

Endometrium

Days 2 4 6 8 10 12 14 16 18 20 22 24 26 28

Ovulation

Menstrual cycle in understanding EC

- 2 halves menstrual cycle- follicular and luteal phase
- Follicular phase is variable- ovaries getting ready to release dominant follicle
- Oestrogen levels rise from ovaries→positive feedback to pituitary→ LH release which peaks and signals ovulation from ovary
- Ovulation varies woman to woman, cycle to cycle
- Luteal phase (after ovulation) is fixed, 14 days
  - 'Secretory'- phase preparing for implantation
  - Key to understanding when ovulation occurs
    - i.e 28 day cycle- day 14 ovulation
    - 30 day cycle- day 16 ovulation

Menstrual cycle in understanding EC

- Oral EC works to prevent ovulation and therefore fertilisation so need to estimate ovulation
- One of ways Copper IUD works is preventing implantation
  - As can’t disrupt an implanted pregnancy, important to know ovulation/estimated implantation
- Can’t fertilise an egg without sperm
- Sperm live for 5 days and ovum 24h
  - Highest risk is 5 days before ovulation and 24h that ovum survives
  - 1 in 3 pregnancy risk
- If fertilisation occurs- copper IUD must be fitted before implantation (no later than 5 days after ovulation)

When is EC needed?

- **On any day** of a natural menstrual cycl
- From Day 21 after childbirth
  - **Unless all criteria** for lactational amenorrhoea are met.
- From Day 5 after any pregnancy
  - Miscarriage, abortion, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
- Contraception compromised/ used incorrectly
  - Including use of enzyme-inducing drug or vomiting
- If intrauterine contraception is removed/expulsion after UPSI.

What about contraception and perimenopause?

- Menopause diagnosis (not using hormonal contraception)
  – Amenorrhoea 12 months
  – Contraception no longer required if >50 yo
- If on progestogen only contraception so can't determine periods
  – **>50 yo and had bloods- FSH >30**
  – **12 months later can discontinue contraception**
- Otherwise progestogen only contraception (except DMPA) should be continued until age 55 yo

Basics/the law

- A judicial review in 2002 concluded that pregnancy begins at implantation
- EC must either prevent fertilization or prevent implantation rather than disrupting established implantation
- Must be discussed in context of different cultural/religious beliefs

Pitfalls in calculating risk

- Sure of LMP?
- Can they remember when they had sex!
- No woman has exactly 28 day cycle to the hour
- How may times has she had sex
- Variable natural fertility

CHOICE OF EMERGENCY CONTRACEPTION

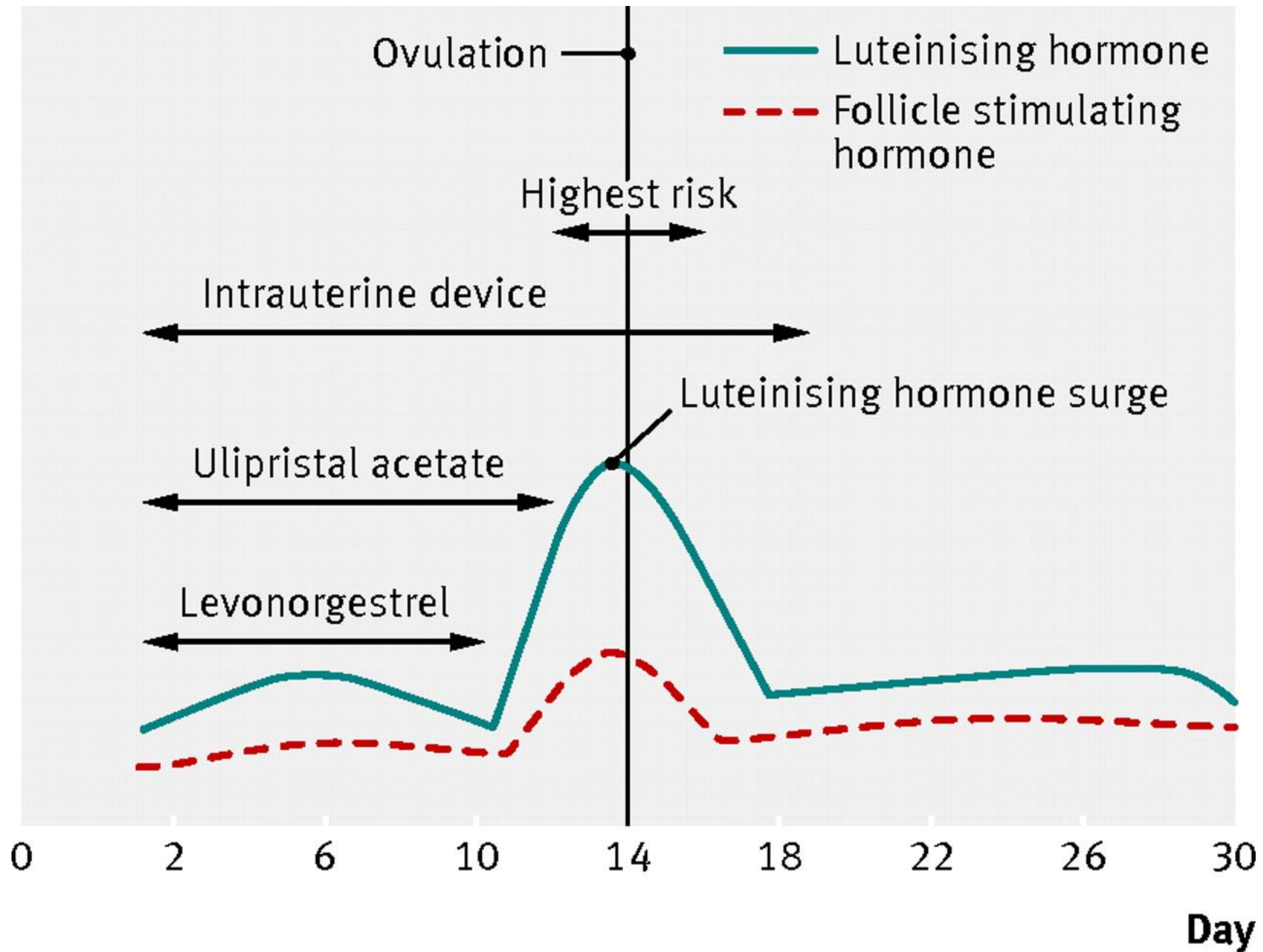
Oral EC

- **Single dose levonorgestrel 1.5 mg (Levonelle)**
  - Can be purchased over the counter, age 16 and over (Boots £10- £26.49)
  - Licensed for use up to 72h after UPSI
  - **Supported by FSRH CEU up to 96h**
- **Ulipristal/UPA "ellaOne"**
  - A selective progesterone receptor modulator
  - Single dose 30 mg. (Cost Boots £30)
  - **Shown to be more effective than LNG-EC 0-120 hours after UPSI**
  - Licensed for use up to 120h after UPSI or contraceptive failure.

Emergency Copper IUD

- **10 x more effective than oral EC**
- ~ 1 in 1000 will get pregnant with IUCD
- ~ 1 in 100 will get pregnant after oral EC
- Provides ONGOING non hormonal contraception
  - Lasting 5-10 years

Fig 1 Window of action of different emergency contraceptive methods in relation to ovulation.



BMJ

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What and why do we ask?

- Check that they are not already pregnant
  - If UPSI was > 21 days ago and no normal period, <u>pregnancy must be excluded</u>
- Identify level of risk of pregnancy (time in cycle)
- Drugs → decrease EC efficacy
- Cautions e.g porphyria, pregnancy, hypersensitivity
- Previous contraceptive use and plans for the future

What and why do we ask?

- Consider any issues of non- consensual SI
- Legal guidance for Under 16's
- Consider child protection referral needs/ CSE
- Remember STIs
  - Especially if under 25's, female recent partner changes).
  - Free dual screening and condom package

How to assess risk?

- When did you have sex?
- Have you had any other sex since last period?
- When was your last period and was it normal?
- What is the shortest number of days between your periods?
- How long do you bleed for?
- Work out day of cycle?

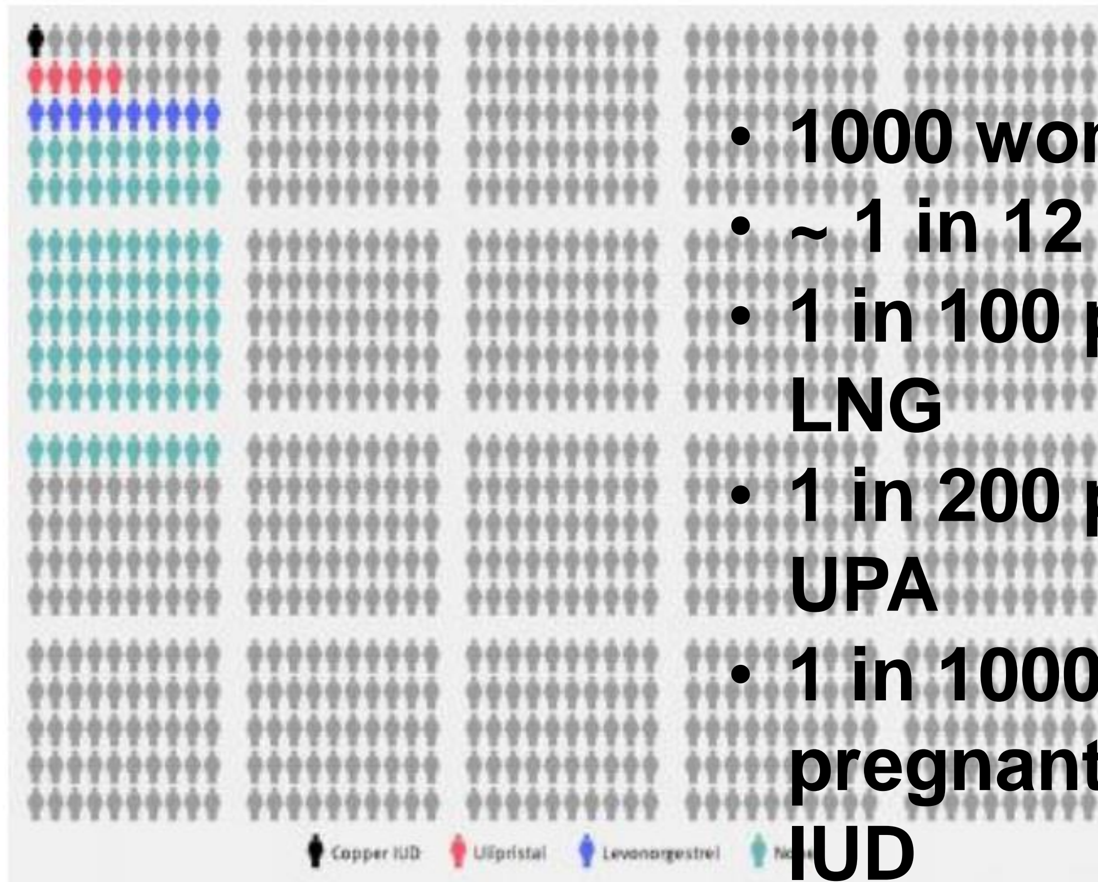
How to work out which day in cycle?

- 22/3/23 today
- LMP 15/3/23 day 1 **– day 8 today**
- UPSI 21/3/23- **on day 7**
- Shortest cycle 25 days
- **Estimated date ovulation: 25-14 = day 11 (25/3/23)**
- Not yet ovulated
- Will ovulate in 3 days….high risk, sperm still alive

What you need to tell them

- Oral EC must be given **as soon as possible** to delay ovulation
- No point taking oral EC >5 days after UPSI
  - sperm dead!
- Mid cycle (highest risk)/
  - Only a Cu-IUD can still stop the pregnancy if it is inserted before implantation
- **Copper IUD is the most effective EC**
- **Offers ongoing contraception**
  - Will be prioritised in sexual health

Fig 2 Comparative predicted estimates of the number of pregnancies expected if 1000 women used various forms of emergency contraception or nothing.



- 1000 women
- ~ 1 in 12 no EC
- 1 in 100 pregnant LNG
- 1 in 200 pregnant UPA
- 1 in 1000 pregnant Copper IUD

Prabakar I , and Webb A BMJ 2012;344:bmj.e1492

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How does it work? Cu-IUD

- Inhibition of fertilisation
- Toxic effect on sperm and ova.
- If fertilisation occurs → local endometrial inflammatory reaction prevents implantation.

How does it work? Cu-IUD

- A pregnancy doesn't implant during the first 5 days after fertilisation
- **For fertilisation you need UPSI/sperm!**

  1. So a Cu-IUD for EC can be inserted within 5 days after the first UPSI in a cycle

- **Shortest time from ovulation to implantation is 6 days so to be on the safe side**

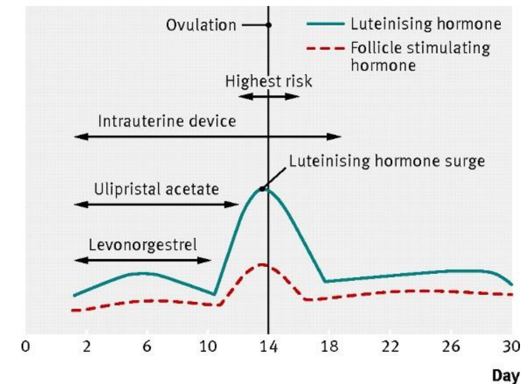
  2. A Cu-IUD for EC can be inserted up to 5 days after the earliest likely ovulation (even if multiple UPSI that cycle)

  WHICHEVER of 1. or 2. IS LATER in cycle

If a copper IUD would be most appropriate or patient request….

- Offer oral EC and signpost to Sexual health
- Patient can request an ‘urgent’ telephone triage appointment

How does it work? UPA-EC

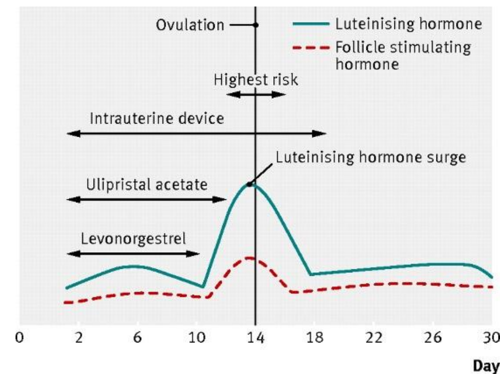


- Selective progesterone receptor modulator.
- Acts by delaying ovulation for at least 5 days
  - Until sperm from the UPSI are no longer viable.
- It delays ovulation even after the start of the LH surge but **not effective after ovulation.**
- **UPA demonstrated to be more effective than LNG-EC**

How does it work? UPA-EC

- After UPA-EC, the majority of women will go on to ovulate later in the cycle →
  - Risk of pregnancy from subsequent UPSI.
- Efficacy may be reduced
  - BMI >30m^2 or weight greater than 85kg.
  - Double dose UPA –EC is not currently recommended.

How does it work: LNG-EC



- Inhibits ovulation, delays/prevents follicular rupture, luteal dysfunction.
- Needs to be taken **prior to the start of LH surge**
- Inhibits ovulation for 5 days until sperm not viable.
- Unlikely to be effective after ovulation

How does it work: LNG-EC

- After LNG-EC, risk of pregnancy from further UPSI.
- Efficacy dependent on timing of UPSI in relation to ovulation.
- Women >70kg or BMI >26
  - Offer double dose (3mg) LNG-EC (if copper coil and UPA-EC are not appropriate.)
- Double dose LNG enzyme inducers (off label but on PGD)

How effective is Levonelle

- Only evidence of efficacy at 96 hours none at 120 hours.
- Licenced for up to 72 hours
- PGD allows up to 96 hours (off licence)

Which oral EC to offer?

- LNG does not work near/after ovulation
- UPA can delay ovulation closer to time of ovulation
  - Would consider UPA if they present 5 days leading up to estimated date of ovulation
  - **BUT they will ovulate later that cycle!**
- **What about hormones?**

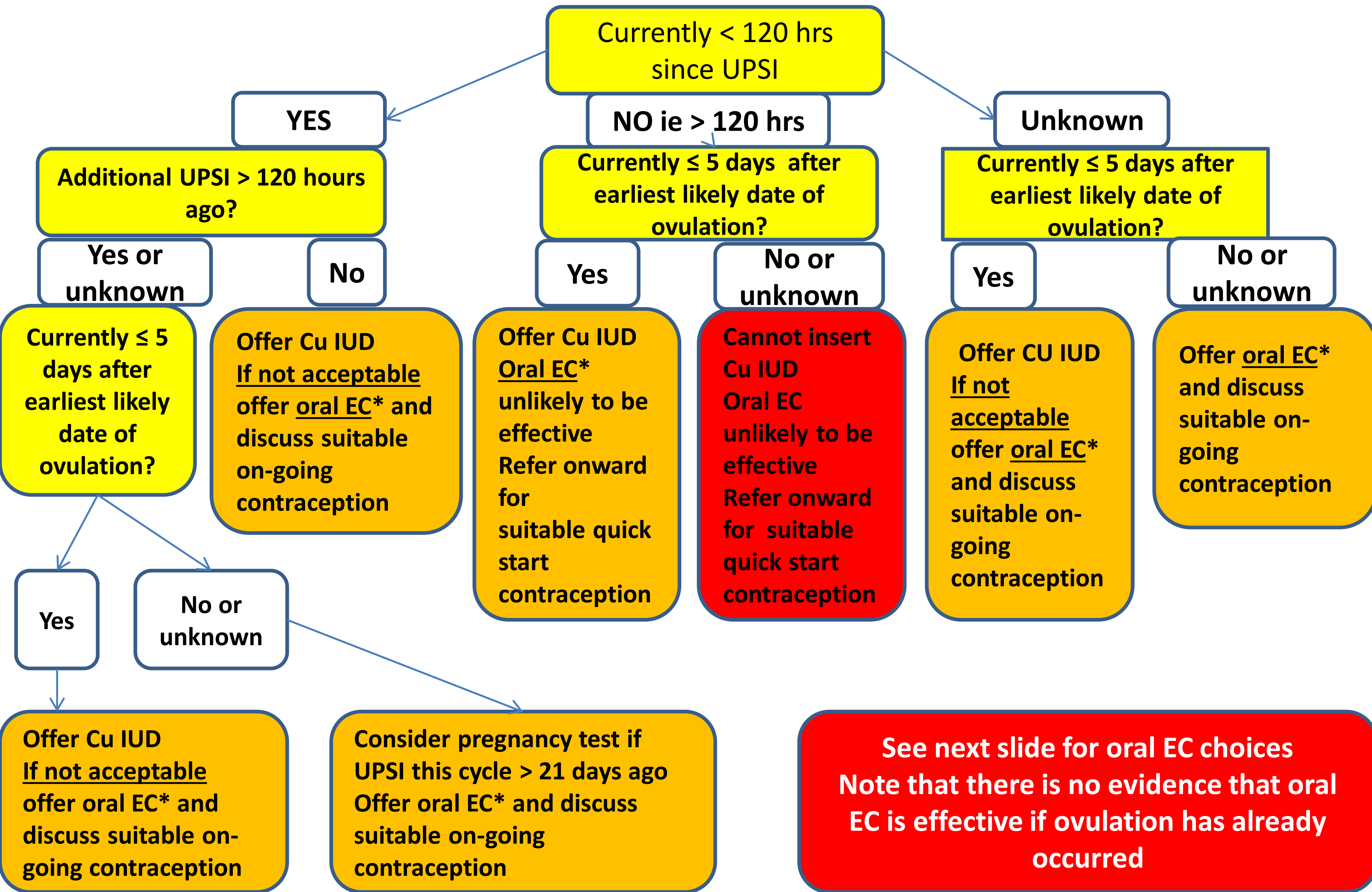
What about hormonal contraceptive failure?

- UPA-EC is a progesterone receptor modulator
- Initiation of **hormonal contraception has to be delayed** for 5 days after UPA
- UPA could be less effective if a **progestogen taken in previous 7 days**; including LNG .

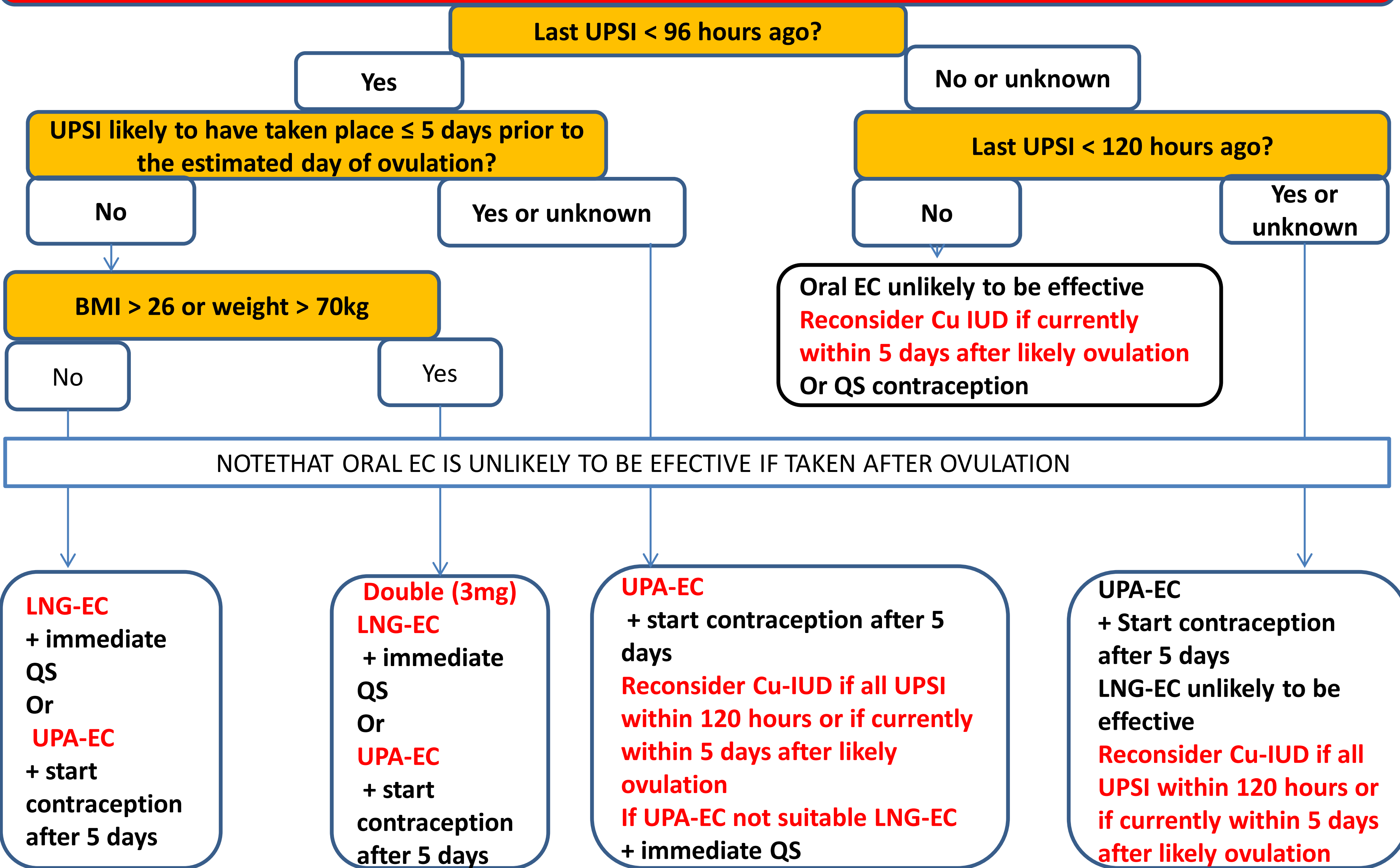
Can you give repeat dose of oral EC within same cycle?

- Yes!
- If LNG-EC in previous 7 days
  - Offer LNG-EC again (not UPA-EC)
- If had UPA-EC within previous 5 days
  - Offer UPA-EC again (not LNG-EC)

Making decisions Algorithms for Emergency Contraception FSRH guidance 2017 Copper IUCD vs Oral EC (adapted for pharmacists)



Decision making for oral EC Levonorgestrel E0C (LNG EC) vs Ulipristal Acetate EC (UP-A-EC) adapted for PGD



IUCD vs oral EC

- Has she had UPSI in the last 5 days?
  - If not, oral EC is unlikely to be effective (?IUCD)
- Is she likely to have ovulated?
  - Yes: explain that oral EC is unlikely to work (?IUCD)
  - No: If given oral EC will ovulate later in month further risk
- If UPSI in the fertile window?
  - Yes: Copper IUD most effective
  - If declines, UPA-EC (if appropriate) is more effective than LNG-EC and works closer to ovulation

Inclusion for LNG and UPA on PGD
Who is eligible?

- Any individual presenting for EC
  - Between 0 and 96 hours (LNG)
  - Between 0 and 120 hours (UPA) following UPSI
- Or when regular contraception has been compromised or used incorrectly.
- No contraindications to the medication.
- Informed consent given

Exclusion criteria LNG/UPA
Who is not eligible?

- Informed consent not given.
- <16 years old and assessed as lacking capacity to consent using the Fraser Guidelines.
- > 16 years of age and over and assessed as lacking capacity to consent.
- **This episode of UPSI occurred more than 96 hours ago for LNG and 120 h for UPA**
- N.B. A dose may be given if there have been previous untreated or treated episodes of UPSI within the current cycle
- Known pregnancy
  - Pregnancy risk is not exclusion.
  - Consider pregnancy test if >3 weeks after UPSI and no normal menstrual period since UPSI.
- <21 days after childbirth.
- <5 days after miscarriage, abortion, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease
- Known hypersensitivity
- **UPA in the previous 5 days (for LNG only).**
- Acute porphyria.

Additional exclusions for UPA

- LNG EC or any other progestogen in previous 7 days
  - (not generally advised in missed pill situation)
- Concurrent use of antacids, PPI, H2 rec antagonists
- Severe asthma controlled by oral steroids
- Use of enzyme inducers/herbal products or within 4 weeks of stopping
- Breast feeding (express/discard 7 days after UPA)
- If going to start a progestogen within 5 days of UPA

Cautions for UPA/LNG

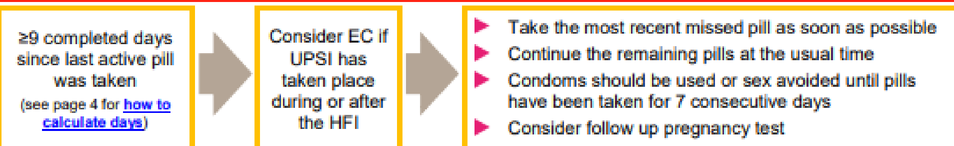
- Repeat dose vomiting <3h
  - Can offer repeat dose
- Current disease status
  - Severe malabsorption syndromes eg. acute/active inflammatory bowel disease or Crohn's disease.
  - Oral EC not contra-indicated but may be less effective
  - Advise that Cu-IUD would be the most effective EC for them
- **<13yo → safeguarding referral**
- Not reached menarche
  - Referral for further assessment or investigation

HORMONES AND EC

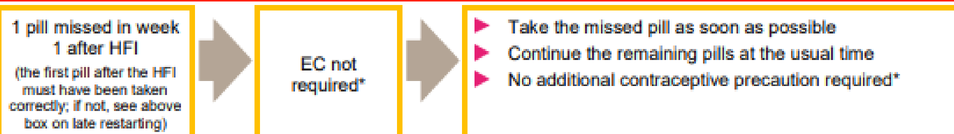
INCORRECT USE OF COMBINED HORMONAL PILL

Guidance on actions after incorrect use of combined oral contraception (monophasic ethinylestradiol COC without placebo pills only)

Late restarting after HFI



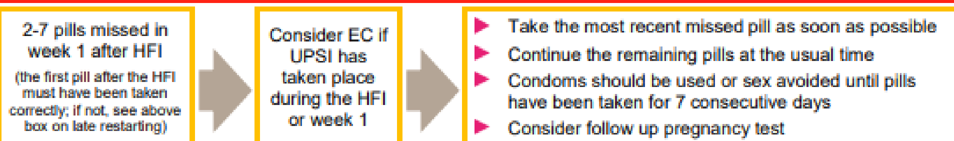
1 missed pill (48 to <72hours since last pill in current pack was taken)

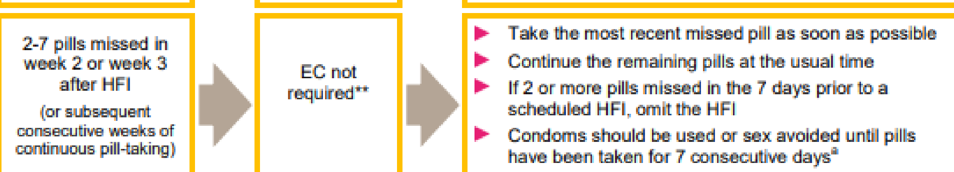


* if consistent, correct use earlier in week 1 and the 7 days prior to the HFI

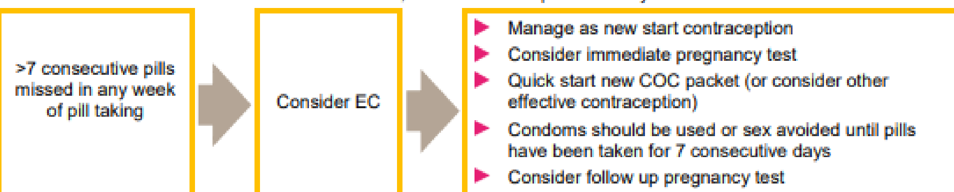
**if consistent, correct use in the previous 7 days

2 or more missed pills (≥72 hours since last pill in current pack was taken)





**if consistent, correct use in the previous 7 days



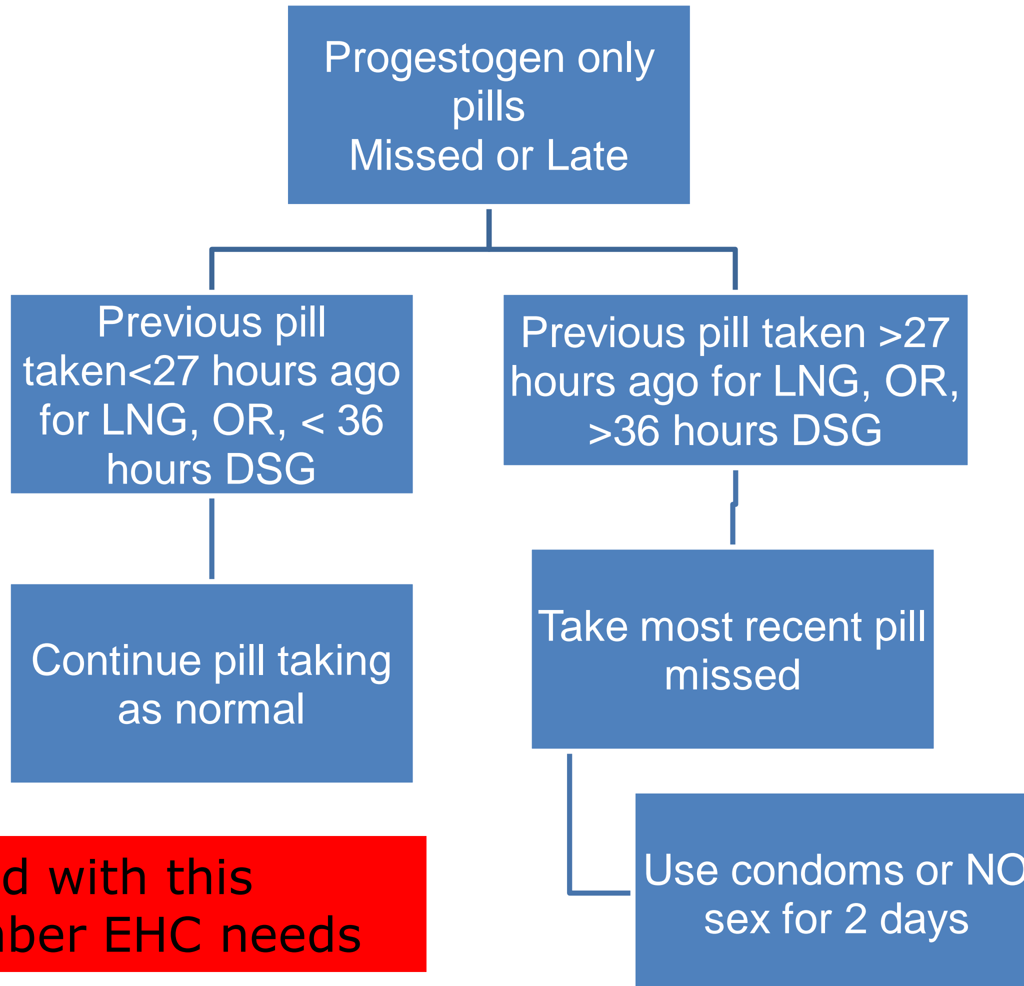
[a] Overcautious, but a back-up in case of subsequent incorrect use

Abbreviations: COC, combined oral contraception; EC, emergency contraception; HFI, hormone-free interval; UPSI, unprotected sexual intercourse

If the pill-free interval is extended after HFI

Cu-IUD can be offered up to 13 days after the start of the HFI assuming previous perfect use

Incorrect use of POP



If not complied with this advice remember EHC needs

- Timing of ovulation after missed pills cannot be accurately predicted.
- A Cu-IUD only recommended up to 5 days after the first UPSI following a missed POP

Nexplanon and IUC

Nexplanon > 3 years

IUD/ IUS use longer than prescribed length of use

Cu-IUD's last between 5-10 years

LNG IUS 52mg 5 -6 years. Age at insertion changes length of use.

If UPSI consider EC (see next slide)

Copper IUD's inserted >40 can retain until 55 yo for contraception

LNG IUS 52mg inserted >45 years can retain until 55 yo for contraception

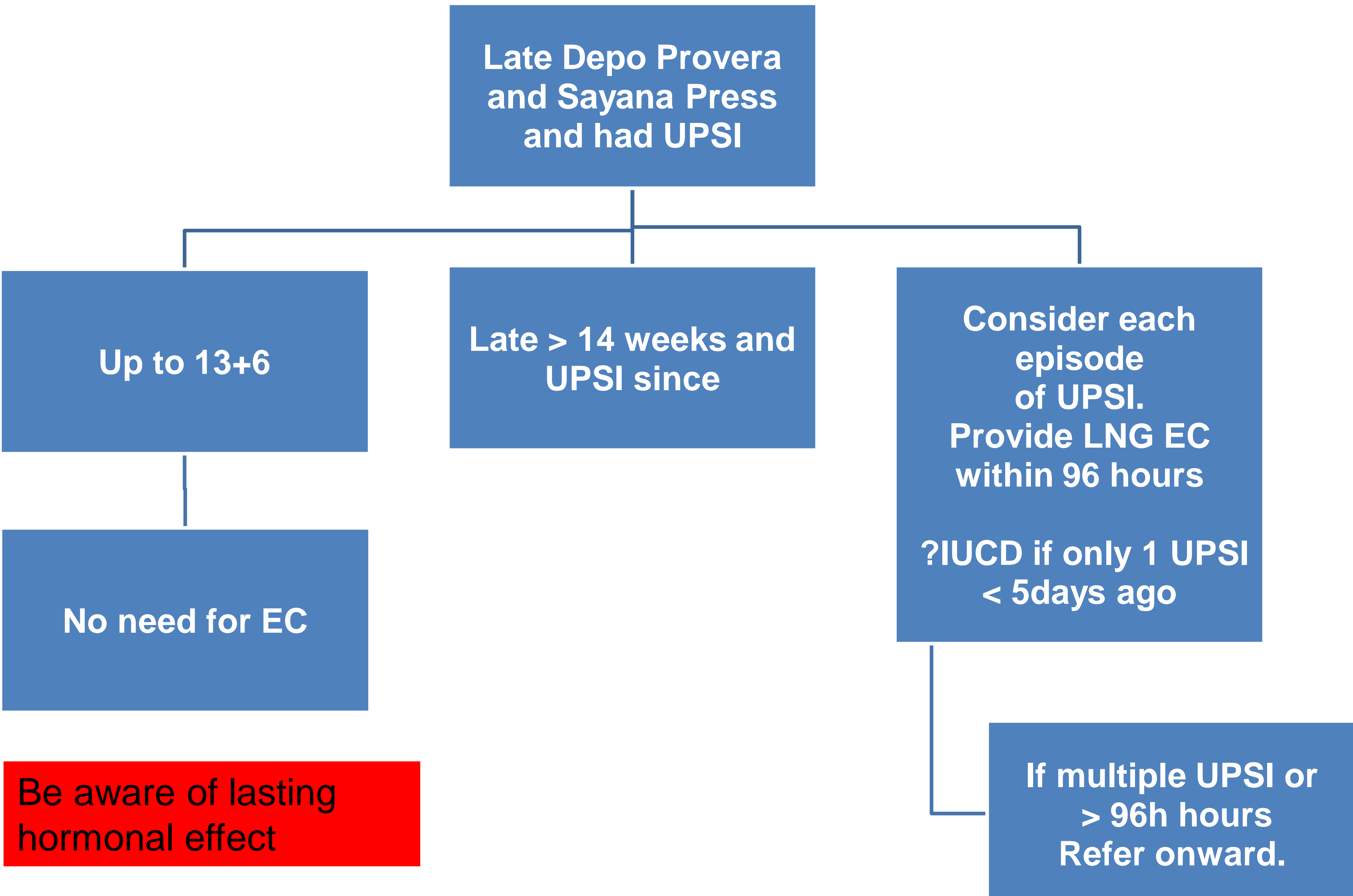
Negligible risk between 5-7 years of use IUS

Negligible risk years 3-4 for Nexplanon users

Extended use of Nexplanon/LNG IUS 52mg

- Risk of pregnancy in the fourth year of use of Nexplanon is low
- Risk of pregnancy in sixth year of use of the 52mg LNG-IUS is extremely low
- Emergency contraception is unlikely to be required.
- The effectiveness of UPA in the presence of progestogen from a recently expired IMP or LNG-IUS is unknown.
- If UPA is given, hormonal contraception should not be started for 5 days after

Late injectables



Summary of oral EHC

- **UPA-EC can be used again in same cycle after further UPSI**
- **LNG-EC can be used again in same cycle after further UPSI**
- If taken UPA-EC, LNG-EC should **not be** taken in next 5 days
  - wait 5 days before starting hormonal contraception then wait until effective
- If taken LNG-EC/progestogen <7 days before ,
  - UPA-EC could be less effective
- After LNG-EC
  - Contraception can be started as a quick start method and should be encouraged with condoms or abstain until this method is effective

Summary of oral EHC

- If Cu IUD is not chosen
  - Consider UPA-EC as first line EC for UPSI within last 120 hrs and or if likely to have occurred in 5 days prior to and including estimated day of ovulation. HIGH RISK
- Breast feeding
  - Express milk and discard for 7 days after taking UPA-EC
  - Explain: ‘evidence (limited) that no adverse effect in breast feeding or infants’
- Inform: possible that higher weight/ BMI could reduce the effectiveness of oral EC , particularly LNG-EC

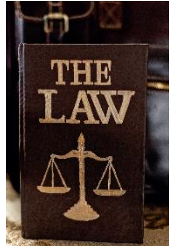
Managing a request for EC

- Where does it take place?
- Confidentiality to be ensured
- No conversations overheard
- No added embarrassment
- Privacy and dignity

Who is the EC for?

- Age 13 and over
- Confirm Fraser competencies for <16
- Caution with >16 years with learning difficulties or mental capacity problems
- Consider child protection concerns
- Domestic or emotional abuse
- Child sexual exploitation
- Remember professional curiosity

Confidential interview and advice



- Limitations to this
- May have to information share if any concerns about their safety or the safety of others
- Explain that sex under 13 is a sexual offence and has to be reported
- Sex 13-16 is currently illegal however this is judged as confidential if there are no features that cause concern.

Consent to treatment

- For young people <16 years, competence to consent has to be demonstrated

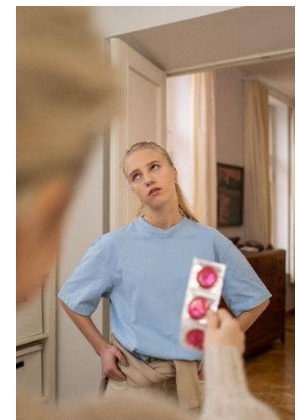
- Fraser Competence assessment
  - If a young person is believed to be < 16 years of age
  - Discussion with the young person should explore the following issues at each consultation.

Fraser or guidance checks for <16’s

- Is a parent or guardian present?
  - If no, check who is with them
- Are they mature enough to **U**nderstand advice/ implications
- Try to **P**ersuade them to talk to a parent/guardian about relationship and sexual health
- Likely to continue having **S**ex with or without advice
- Without advice/ treatment their physical or mental health would **S**uffer
- It is in their best **I**nterest that treatment/advice is given without parental consent.
- **REMEMBER UPSSI**

After care and follow up

- Give written and verbal information on:-
  - Efficacy, Side-effects
  - Future contraception choices
  - STI screening where appropriate
    - Chlamydia screening
    - Freely available for under 25’s in sexual health and pharmacies
  - Pregnancy test
    - 21 days after UPSI



Timing of next period

- Should arrive ± 3 days of expected date.
- Periods/ bleeding may be irregular
  - Especially if other EC taken within the cycle
- More EC taken in any cycle
  - Greater disruption of menses

Future contraception

- Abstinence (if have UPA) or effective contraception for the rest of the cycle
- Discussion/signposting about LARC
- Refer to a service that provides all methods for choice
- Quick start of methods after emergency contraception

Dual screening and free condom kits

- Chlamydia & Gonorrhoea are the most common STIs in England
  - More common in <25
  - Easy to treat and cure.
  - Most people no signs or symptoms.
- UK Health Security Agency
  - New guidance regarding target audience for dual screening - young people <25.
- Aims of the National Chlamydia Screening Programme
  - Focus on reducing the harms from untreated chlamydia infection in women
  - Associated with high morbidity
    - Reproductive health- PID, ectopic pregnancy, chronic pain

Dual screening and free condom kits

- Free Dual Screening kits can be supplied free of charge as part of the National Chlamydia Screening Programme (NCSP) to <25
  - Attract a £1 supplement paid by the Council for each kit supplied and claimed using Pharmoutcomes template
  - Delivered within 10 days
- Encourage community partners to offer opportunistic screening
  - Focus on sexually active females attending for EC
- With proactive offer of a dual screening and condom pack
  - Dual screening/condom offer and pathway p found here: https://bit.ly/3Jx0qKe

What is happening with dual screening?

- Across Gateshead and South Tyneside
  - 27 Pharmacy sites on the scheme and have the dual screening kits in stock.
- In the last 12 months
  - **55** dual Screening tests have been returned with **7** out of **55** testing positive
- 13% positivity.
- NB- some wastage to which service users collect /accept offer of kits take them home and never return them

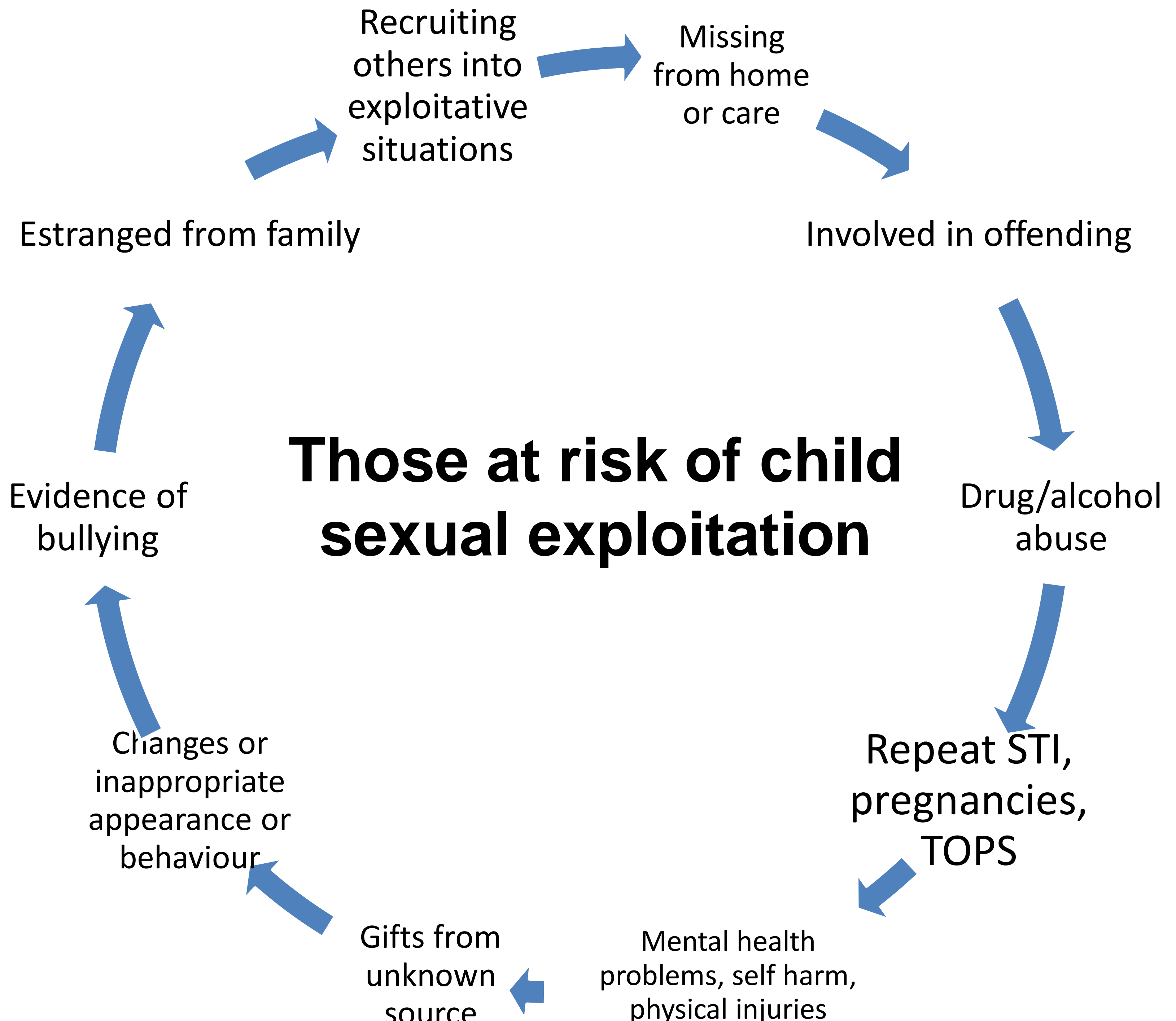
SAFEGUARDING

Worried about something else?

- Gut feelings
- Think < 13 (statuary rape, cannot consent)
- Signs of self harm
- Seen them before
- Remember girls or women of any age may be affected by domestic abuse or violence.

Some signs, which may raise suspicions

- May smell of alcohol
- Lack of eye contact and engagement
- Unexplained bruising, scalds, marks
- Have expensive phones, gifts , new possessions
- Should be at school (so now missing from school)
- Have older boyfriend or girlfriend with them
- Staying with friends, sleeping on sofas(no home adress)
- Behaving aggressively


Those at risk of child sexual exploitation
Recruiting others into exploitative situations
Missing from home or care
Involved in offending
Drug/alcohol abuse
Repeat STI, pregnancies, TOPS
Mental health problems, self harm, physical injuries
Gifts from unknown source
Changes or inappropriate appearance or behaviour
Evidence of bullying
Estranged from family

CSE or safeguarding concerns

- If under 13 legally cannot consent to SI so is classed as sexual offence.
- Ring 999

Gateshead Safeguarding Team Details **Last update March 2023**		
Integrated Referral & Assessment Team (IRT) (Children Services)	Gateshead Council	Civic Centre, Gateshead Office Hrs Tel No: **0191 433 2515/2653** Email: **R&ADuty@Gateshead.Gov.UK** Out of Hours Tel No: **0191 4770844** Email: **EDT@Gateshead.Gov.UK** Online referral form (child Protection) **https://www.gatesheadsafeguarding.org.uk/article/9298**
Safeguarding Unit	Gateshead Council	Civic Centre, Gateshead Tel No: **0191 433 3565** Email: **SafeguardingChildrenUnit@Gateshead.Gov.UK**
Dr. Neelmanee Ramphul	Designated Doctor (QE)	Queen Elizabeth Hospital Tel No: **0191 482 0000** Email: **n.ramphul@nhs.net**
Trina Holcroft	Designated Nurse, Safeguarding Children (ICB)	North East & North Cumbria ICB, Riverside House Tel No: **0191 217 2552** Mob No: **07585403072** Email: **tholcroft@nhs.net**
Maxine Duffy	Named Nurse (safeguarding children) (QE)	Paediatric Department - Queen Elizabeth Hospital Tel No: **0191 445 2049** Safeguarding Admin Tel No: **0191 445 2248** Mob: **07970261784** Email: **maxineduffy@nhs.net**
Rachael McDougall	Named Nurse Child Protection (HDFT)	0-19 Service Gateshead - Harrogate and District NHS Foundation Trust Tel No: **07741700425** Email: **rachael.macdougall@nhs.net**
Linda Hubbucks	Designated Nurse for Looked After Children	Tel No: **0191 2172828** Mob: **07769362016** Email: **Linda.hubbucks@nhs.net**

Referral Pathway South Tyneside contraception, emergency IUCD/advice

- South Tyneside 0191 4028191 all services to one location Palmer CH
- Reception open in clinic times
- SRH service provides all methods.
- Some GP surgeries insert IUD's
- Some GP surgeries insert Nexplanon
- SRH service open 6 days each week with
- Emergency IUD insertion available each day Mon - Fri

Referral Pathway Gateshead for contraception and Emergency IUCD

- Gateshead 0191 2831577 clinic reception
- Emergency IUCD Mon- Fri
- SRH service open 6 days per week
- GP surgeries inserting IUD and inter-practice referrals but may not have appointment for emergency
- SRH service provides all methods.
- Some GP surgeries insert Nexplanon
- SRH service open 6 days each week

Q

WHAT DO YOU KNOW NOW?

What do you know now?

Emergency contraception

Quiz

Part 2

Question 1

Gemma is 15 years old. She is taking the combined pill Microgynon for her contraception. She took her planned hormone free interval (7 day break), but missed pills 1-9 in her new packet. Since taking her last pill 16 days ago she tells you she has had multiple episodes of UPSI, her last was about 12 hrs ago.

Gemma should attend a service that can offer EMIUCD?

- True
- False

False

- FRSH – Ovulation may occur if CHC is used incorrectly during week 1 of pill pack OR if the HFI is extended. Non compliance of CHC in week 1 should be considered an extension of the HFI. Ovulation in these cases can not be predicted on an individual basis. Systematic reviews have shown earliest date for ovulation to occur is 8 days after the last correctly taken pill in the previous packet. Due to this an EM-IUCD can be inserted up to 13 days after the start of the HFI (assuming the earliest time from fertilisation to implantation is 5 days.)
- Gemma took her last pill 16 days ago so has exceeded the 13 days for an IUCD to be inserted.
- Gemma could be offered LNG if she intends to restart her CHC immediately or UPA if she does not want to continue with CHC.

Question 2

Sinead is 22 years old. She attends requesting oral EC only. She tells you she had UPSI 16 hrs ago and that her LMP was 15 days ago, her cycles are 26 days in length. On history taking she tells you she takes Provigill. **What would you offer Sinead. Pick 2 answers.**

A) Double dose of LNG 3mg

B) Single dose of UPA 30mg

C) Double dose of UPA 60mg

D) Single dose of LNG 1.5mg

A&B

- Sinead is taking Provigil (Modafinil) which is an enzyme inducer. FRSH guidance suggests that the effectiveness of both oral EC methods *could* be reduced.
- Sinead should be fully informed of this and that the most appropriate and effective EC for her is the EMIUCD, however if she does not want this option, a double dose LNG-EC 3mg can be offered within 96 hrs of UPSI (off licence) although the effectiveness of a double dose in this situation is unknown.
- The effectiveness of UPA for emergency contraception could be reduced. The Use of a double dose UPA is not recommended. The effectiveness of UPA compared to that of double-dose (3mg) LNG in this situation is unknown.

Question 3

Sarah has a 4 month old baby who has been increasingly hungry. She has been worried her milk supply is getting low. She has been adding in one bottle of formula a day for the last 2 weeks. She has had multiple episodes of UPSI over the last few weeks but can't be specific – she is sure she her last UPSI was about 96-98 ago though. She is amenorrhoeic. Her friend has told her she could get pregnant – **what would you advise?**

A) She is at risk of pregnancy and could be offered LNG

B) She is at risk of pregnancy and could be offered an EMIUCD

C) She fulfils the criteria for LAM and this is >98% effective

D) She is at risk of pregnancy and could be offered UPA

D

- As Sarah has introduced formula she does not meet the criteria for LAM (baby 6mo or younger, amenorrhoea, exclusively breast fed). Therefore she is at risk of a pregnancy.
- Sarah would not be eligible for an EMIUCD as multiple episodes of UPSI over the last two week, so exceeds the 120 hr rule, as she is amenorrhoeic we can not in this situation predict ovulation so an EMIUCD cannot be fitted.
- As it is over 96 hrs from her last UPSI, Sarah could be offered UPA 30mg.

Question 4

Would you give Sarah and additional advice?

Yes

- Sarah should be informed that UPA can be excreted in breast milk. FSRH guidance supports the use of UPA in breast feeding mothers but they should be advised to express and discard breast milk for a week after taking UPA.

Question 5

Tabby is 37 years old, her BMI is 28. Her LMP was 15 days ago, she has a regular 29 day cycle. She had a contraceptive implant fitted 3 days ago, but reports UPSI 27hrs ago. She has done some research and does not want an EMIUCD. **What would you offer Tabby?**

A) UPA 30mg

B) LNG 1.5mg

C) LNG 3mg

D) EC not indicated as Tabby has an implant

C

- Tabby had an implant fitted 3 days ago – however this will take 7 days before effective so she is at risk of a pregnancy. As she has commenced a hormonal contraceptive method UPA would not be indicated for Tabby.
- Tabby can have LNG – as her BMI is >26 she should be offered 3mg.

THANK YOU