

Information required by Emergency Care to Sexual Assault Victims Act

(S.F. 1266/Ch. 42)

Background

A law was passed during the 2007 legislative session requiring the Minnesota Department of Health to provide Minnesota hospitals with information about emergency contraception from the American College of Obstetricians and Gynecologists (ACOG). Minnesota hospitals are required to provide this information to victims of sexual assault. The information in this fact sheet comes directly from the ACOG Web site, at http://www.acog.org/departments/dept_notice.cfm?recno=18&bulletin=1084.

Frequently asked questions about hormonal approaches to emergency contraception

1. What is emergency contraception?

Emergency contraception (EC) is a term that describes the use of contraceptive methods to prevent pregnancy after unprotected or incompletely protected intercourse. The approach most often used is the ingestion of combined oral contraceptives (COC) or progestin-only pills (POP) within 72 hours of unprotected intercourse. Several regimens of different formulations can be used for EC:

Yuzpe regimen: Two tablets of Ovral (50 mcg ethinyl estradiol plus 0.5 mg norgestrel) followed in 12 hours by 2 additional tablets.

Formulations of sub-50 mcg COCs.

"Preven": The equivalent of the 2 Ovral doses of 2 tablets each).

"Plan B": One tablet of 0.75 mg levonorgestrel followed in 12 hours by 1 additional tablet.

As an alternative to the hormonal approach, an intrauterine device can be very effective for EC when it is inserted within 5 days of unprotected intercourse. IUDs must be inserted and removed by a physician. This method may be appropriate for women seeking long-term

contraception; however, it is not advisable for women at high risk for sexually transmitted diseases or for adolescents. Furthermore, insertion of an IUD is not recommended for EC in cases of rape.

2. What is meant by "incompletely protected" intercourse?

Approximately half of unintended pregnancies in the U.S. result from a contraceptive method failure. Commonly experienced examples of such failure are condom slippage or breakage or multiple missed pills in a cycle of pill use. (http://www.acog.org/departments/dept_notice.cfm?recno=18&bulletin=1077)

3. What is the mechanism of action of COCs or POPs in providing emergency contraception?

Before ovulation, treatment with EC is believed to disrupt follicular maturation and consequently inhibit or delay of ovulation. After ovulation, treatment appears to have no effect on ovarian hormone levels. Thus, prevention of implantation may be a secondary mechanism of action. In addition, POPs alter tubal motility.

4. Does this mean that emergency contraception can cause an abortion?

Emergency contraception will not disrupt an established pregnancy. Women often are exposed to exogenous hormones in early pregnancy without adverse outcome. Some women undergoing assisted reproductive technology procedures to achieve pregnancy are routinely prescribed progesterone to support the pregnancy. It is also a common occurrence to interview patients in early pregnancy who were not aware that their missed pills had resulted in contraceptive failure and who thus had continued taking their pills.

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5. How effective is emergency contraception?

Effectiveness is determined by comparing the number of pregnancies observed with treatment to the number that would have been expected without treatment. Women who utilize emergency contraception in the most fertile segment of the menstrual cycle (6 days preceding ovulation to the day after ovulation) will have a higher failure rate than women who utilize the method during another part of the cycle. The proportion of pregnancies prevented with the Yuzpe regimen has been calculated to be between 57-75%. The effectiveness of the levonorgestrel regimen is reported to be 85%. The effectiveness of all regimens decreases after the first 12-24 hours after unprotected or incompletely protected intercourse.

6. Is there any point in using EC after 24 hours?

Although the reduction in the risk of pregnancy is most striking in the first 12-24 hours, EC can be effective for up to 72 hours. Based on combined COC and POP method use, the World Health Organization (WHO) has reported pregnancy rates of 0.5%-1.5% in the first 12-24 hours compared to approximately 2.6% at 48 hours and 4.1% at 72 hours. To reduce unintended pregnancies it is critical to find ways to make EC as readily available as possible to women as soon as the need is recognized.

7. What about having emergency contraception available in advance?

The correlation of low pregnancy rates with early utilization of emergency contraception supports advance prescribing of the dedicated products along with detailed instructions for their use. In addition, it is well known that users of barrier methods and OCPs would benefit from this kind of intervention. Users of OCPs are routinely advised to take a missed pill along with the current pill. Studies have shown that women can identify their risks and needs quickly, will utilize the regimen appropriately when it is provided in advance,

and are not inclined toward repetitive use patterns for EC.

8. What are the side effects associated with EC use?

The most common side effects of EC use are nausea and vomiting. At least 50% of the COC regimen users will experience nausea and 18-20% will have vomiting. The Plan B (levonorgestrel) regimen is associated with less than 25% frequency of nausea and about 5% vomiting. An antiemetic should be offered in conjunction with the EC prescription. Products such as those used for motion sickness are generally sufficient. The dose may need to be repeated if an EC user vomits within 1 hour of taking the medication. An episode of vomiting after 2 hours does not require a replacement

9. In addition to temporary side effects, are there any serious complications of EC?

The short-term nature of the regimen makes any vascular complications such as thrombosis highly unlikely. Menstrual cycle changes such as heavier bleeding, headache, dizziness, and breast tenderness may be experienced by as many 16 % of EC users. Because of the presumed effects on tubal motility with POP regimens, caution should be exercised in evaluating the possibility of ectopic pregnancy in users who experience abnormal bleeding for. There are very few contraindications to using EC: women should not use EC who are already pregnant or who have genital bleeding of unknown cause.

10. What if a woman is already pregnant or if EC fails to prevent pregnancy? What problems may occur?

The use of EC is contraindicated during pregnancy. A woman with a problem pregnancy needs evaluation, counseling, and advice. A woman with an unplanned but desired pregnancy needs exactly the same care from her physician. Menses may be delayed after EC use, and a follow-up visit should be scheduled within 1-3 weeks to check for possible pregnancy. Based on studies of

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pregnancies where EC failed to prevent pregnancy, there is no (finding) that there is any increased risk of birth defects or other problems for the ongoing pregnancy. This finding is consistent with the knowledge that early exposure to estrogen or progestin formulations does not produce adverse embryonic or fetal effects.

11. Should a pregnancy test be performed before using EC?

A pregnancy test is not a prerequisite to the use of EC. It can be useful in determining the need for EC if the woman has experienced more than one episode of unprotected or incompletely protected intercourse in the cycle and at least one episode was greater than 72 hours preceding evaluation. A positive test will allow the woman or her physician to begin the appropriate care for early pregnancy.

12. When should the regular method of contraception be resumed after EC use?

Since EC (both the COC and the POP methods) can delay ovulation, it is important for a woman who is at continued risk for pregnancy to use an effective method of contraception for the remainder of the current cycle. Barrier methods and spermicide can be used immediately. A woman who is using OCPs can start a new pack after beginning the next menstrual cycle or she could even begin with one pill a day of her regular OC on the day after completing the EC treatment regimen.

13. Do EC users become less effective contraceptive users?

Most couples would like to increase their ability to effectively prevent and plan pregnancy. Many EC users are currently using a contraceptive method the best way they can under the circumstances of their lives. Identifying the need for EC and providing it gives a woman an opportunity to enhance personal decision-making for ongoing effective contraception.