



Emergency Contraception Algorithm and Guide for Clinicians

REBECCA STONE
SALLY RAFIE
SHAREEN Y. EL-IBIARY
VERONICA VERNON
NICOLE M. LODISE

In the United States, approximately 45% of pregnancies are unintended, with most occurring in situations in which contraception is used incorrectly, inconsistently, or not at all

(Finer & Zolna, 2016; Sonfield, Hasstedt, & Gold, 2014). Emergency contraception is a postcoital option that can be used up to 120 hours after unprotected intercourse (Cheng,

Abstract There are currently three forms of emergency contraception: oral levonorgestrel, oral ulipristal acetate, and the copper intrauterine device. The copper intrauterine device is the most effective, followed by ulipristal acetate and levonorgestrel, respectively. Although levonorgestrel is the least effective method, studies show that more prescribers are familiar with it and that is the most frequently used method. Clinicians should consider several factors when helping women make informed medical decisions regarding emergency contraception, including access to the products, a woman's individual preference, timing since unprotected intercourse, body mass index or weight, and initiation or resumption of routine contraception. This article explains and summarizes these considerations and provides an algorithm to guide clinicians. <http://dx.doi.org/10.1016/j.nwh.2017.06.005>

Keywords emergency contraception | intrauterine device | IUD | oral ulipristal acetate



Rebecca Stone, PharmD, BCACP, BCPS, is an assistant professor in the Department of Pharmacy Practice at the University of Georgia in Athens, GA. Sally Rafie, PharmD, BCPS, is a clinical pharmacist specialist at University of California San Diego Health in San Diego, CA. Shareen Y. El-Ibiary, PharmD, FCCP, BCPS, is a professor in the Department of Pharmacy at Midwestern University in Glendale, AZ. Veronica Vernon, PharmD, BCPS, BCACP, NCMP, is a clinical pharmacy specialist at the Richard L. Roudebush VA Medical Center in Indianapolis, IN. Nicole M. Lodise, PharmD, TTS, is a professor in the Department of Pharmacy Practice at the Albany College of Pharmacy and Health Sciences in Albany, NY. The authors report no conflicts of interest or relevant financial relationships. They report that in this article levonorgestrel 1.5 mg and the copper intrauterine device are being discussed for an off-label use. Address correspondence to: nicole.stack@acphs.edu.

Che, & Gülmezoglu, 2012; Curtis, Jatlaoui, et al., 2016; Curtis, Tepper, et al., 2016). There are three forms of emergency contraception available: oral levonorgestrel (LNG), oral ulipristal acetate (UPA), and the copper intrauterine device (IUD). The primary mechanism of action of LNG and UPA is to delay or inhibit ovulation, whereas the copper IUD primarily inhibits fertilization through the release of copper ions that are toxic to sperm (Gemzell-Danielsson, Berger, & Lalitkumar, 2013, 2014).

Regulations regarding access to emergency contraception containing LNG have changed multiple times over the past decade, often resulting in confusion among women and health care professionals

All three methods significantly reduce the likelihood of pregnancy; however, the copper IUD is the most effective option, with 99% efficacy in preventing pregnancy (Cheng et al., 2012; Cleland, Zhu, Goldstuck, Cheng, & Trussell, 2012). By contrast, oral emergency contraception options are 40% to 90% effective after a single act of intercourse (Cheng et al., 2012). Efficacy varies within this range based on factors such as timing of the menstrual cycle day, the time elapsed between unprotected intercourse and administration of the product, body weight or body mass index (BMI), and when routine birth control is initiated or resumed after product use. Table 1 provides an overview of available options including safety, efficacy, and use considerations for each product.

LNG is used more frequently than UPA or the copper IUD in the United States; this trend is likely related to product access, the type of provider practice specialty, and/or a clinician's familiarity with available products (Batur et al., 2016; Cleland et al., 2012). The limited use of UPA and the copper IUD, despite their better efficacy when compared with LNG, highlights the need for a succinct guide to aid clinicians in counseling and facilitating selection of the most effective emergency contraception method that is accessible and acceptable to a woman.

This article summarizes five key considerations for clinicians when recommending emergency contraception options and provides a concise overview to help clinicians determine the optimal emergency contraception method for a woman. The algorithm depicted in Figure 1 offers guidance to further aid clinicians with an emergency contraception recommendation based on efficacy, timing since unprotected intercourse, body weight, and access.

Five Common Considerations When Recommending Emergency Contraception Options

Consideration #1: Access

Regulations regarding access to emergency contraception containing LNG have changed multiple times over the past decade, often resulting in confusion among women and health care professionals. Although the elimination of age restrictions for one-dose LNG emergency contraception purchase has simplified access, confusion regarding over-the-counter (OTC) availability of the two-dose generic formulations may still persist. Although one study showed that pharmacists in a community setting provided accurate LNG emergency contraception information in most instances (87%), multiple other studies have shown that misinformation regarding LNG emergency contraception access, particularly regarding age restrictions, continue to create unnecessary barriers for women (Bell, Camacho, & Velasquez, 2014; Orr, Lemay, Wojtusik, Opydo-Rossoni, & Cohen, 2016; Wilkinson, Vargas, Fahey, Suther, & Silverstein, 2014). Currently, LNG one-dose options are available OTC without proof of identification and may be sold to anyone, male or female, regardless of age. LNG two-dose options are no longer manufactured and are being phased out; however, any remaining stock requires a prescription for those 16 years and younger and is OTC for those 17 years and older (Uhl, 2014). Insurance coverage varies, with some states having protocols allowing OTC oral emergency contraception to be billed under insurance, but many may still require out-of-pocket payment for OTC emergency contraception.

UPA is available as a prescription-only product. Low demand and a temporary supply shortage of UPA due to a distribution issue

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