

Sometimes You Do Get a Second Chance

Emergency Contraception for Adolescents



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KEYWORDS

- Emergency contraception • Hormonal contraception • Unprotected intercourse
- Adolescents • Teen pregnancy • Pregnancy prevention

KEY POINTS

- Emergency contraception (EC) needs to be available, accessible, and proactively prescribed and/or discussed with adolescents before the need to use it.
- Counseling about EC does not result in increased sexual activity and can actively help prevent adolescent pregnancies.
- The copper T intrauterine device works very well and provides so-called forgettable contraception for up to 10 years after insertion.
- Ulipristal acetate is less expensive and has efficacy up to 5 days after intercourse, compared with levonorgestrel EC, with efficacy for up to 72 hours after unplanned intercourse.

INTRODUCTION

Emergency contraception (EC) is defined as any medication or device used to reduce the risk of pregnancy after unprotected or inadequately protected sexual intercourse. EC is intended as an emergency rescue measure in women who have had unprotected intercourse or a failure of another contraceptive method and is not intended to be used as a primary contraceptive method. In the United States, there are 4 currently approved methods of EC, including the copper intrauterine device (IUD) and 3 oral methods: ulipristal acetate (UPA), levonorgestrel, and the Yuzpe method (ethinyl

Conflicts of Interest: Dr E.S. Rome serves on the Merck Vaccine Advisory Board and Speakers Bureau. Dr V. Issac has no conflicts of interest.

No internal or external funding has been received for support of this article.

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Pediatr Clin N Am 64 (2017) 371–380
<http://dx.doi.org/10.1016/j.pcl.2016.11.006>

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estradiol plus levonorgestrel). Internationally, mifepristone is also approved in some countries for the purposes of EC. Compared with adults, adolescents are more likely to use contraception intermittently or ineffectively. In addition, adolescents are more likely than adults to use less effective forms of contraception.¹ Thus, sexually active adolescents are at high risk for unwanted or unplanned pregnancy compared with adults and are an important target for EC education and usage. Usage of EC in adolescents greatly improves if they receive counseling and prescriptions for usage before any need arises² (Table 1).

EPIDEMIOLOGY

Despite decreases in the rate of teen births over the past 50 years in the United States, the teen birth rate remains high compared with other industrialized nations.^{3,4} In addition, 82% of pregnancies in girls aged 15 to 19 years are unplanned or unintended.⁵ Thus, adolescents represent an important target group for education not only about ongoing contraceptive options but also in the use of EC after unprotected intercourse, contraceptive failure, or sexual assault. The benefits of EC, in addition to preventing unintended pregnancy, also extend to related consequences of adolescent motherhood, including premature birth, stunted educational and vocational opportunities, decreased rates of high school completion, increased welfare dependence and future poverty rates, decreased psychological functioning, and decreased employment stability.⁶

PREGNANCY RISK

Ovulation usually occurs between days 10 and 21 of the menstrual cycle, most commonly between days 13 and 16. However, because adolescents are more likely to have irregular and/or anovulatory cycles, it is harder to predict when ovulation will occur. The fertile period is estimated to last about 6 days, beginning about 5 days before ovulation. Once an ovum is released, it has 24 hours to be fertilized by a spermatozoon. Spermatozoa remain viable in the female reproductive tract for 5 to 6 days and can fertilize an ovum on release from the ovaries during this time period.

Following a single act of intercourse at an unknown point in the menstrual cycle, there is a 4% to 6% risk of pregnancy.⁷ However, during the most fertile time of the cycle (starting 5 days before ovulation and ending 24 hours after ovulation), this risk increases to approximately a 30% risk of becoming pregnant following a single encounter of vaginal intercourse.^{7,8} Given the uncertainty of timing of ovulation, especially in adolescents, and the prolonged viability of sperm, EC should be encouraged in the setting of contraceptive failure at any point throughout the menstrual cycle. Adolescents suspected to require EC in the fertile window of the menstrual cycle may benefit from one of the more effective methods of EC, such as a copper IUD or UPA.

THE HISTORICAL (AND POLITICAL) PERSPECTIVE

The earliest EC in the United States used high-dose oral estrogen, which had side effects such as nausea and breast tenderness.^{9,10} In the 1970s, the copper IUD as well as the Yuzpe method gained popularity; the latter consisted of a 2-dose regimen of 100 µg of ethinyl estradiol plus either 0.5 mg of levonorgestrel or 1.0 mg of norgestrel given 12 hours apart within 72 hours of sexual intercourse. The Yuzpe method was most commonly used in adolescents until the turn of the twenty-first century, when progestin-only methods were approved and became more popular; these

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