Emergency Contraception (EC)

Emergency contraception (EC) provides women of all reproductive ages with a means of preventing unintended pregnancy following any unprotected sexual intercourse (UPSI).

The section on emergency contraception includes the following types:

- Copper-bearing IUD (Cu-IUD)
- Oral emergency contraception (EC).

FSRH guidance on EC[1] and IUC[2] is available on the FSRH website.

Copper-bearing IUD (Cu-IUD) for emergency contraception
The Cu-IUD is the most effective form of EC. All eligible women presenting between 0 and 120 hours of UPSI or within 5 days of expected ovulation (Day 19 in a regular 28-day cycle) should be offered a Cu-IUD because of the low documented failure rate.

The eligibility criteria for interval Cu-IUD insertion also apply for the insertion of the Cu-IUD as EC. However, the risk-benefit ratio will be different for the use of the Cu-IUD as EC compared to when it is used for routine contraception.

Oral emergency contraception
Two methods of oral EC are available in the UK.

Ulipristal acetate (UPA) is a progesterone receptor modulator that is a synthetic steroid derived from 19-norprogesterone and is licensed for use within 120 hours of UPSI.

Oral progestogen-only EC containing LNG 1.5 mg is licensed to be given up to 72 hours after UPSI or contraceptive failure. There is some evidence of reduced efficacy with use after 72 hours.[3,4]

Emergency Contraception (EC) Copper-bearing intrauterine device (Cu-IUD) Ulipristal acetate (UPA) Levonorgestrel (LNG)	EC do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraception method. Male condoms reduce the risk of STI/HIV.			
CONDITION *See additional comments at end of section	CATEGORY			CLARIFICATION/EVIDENCE
	Cu-IUD	UPA	LNG	
Pregnancy	NA	NA	NA	**Clarification:** There is no known harm to the woman, the course of her pregnancy or the fetus if UPA or LNG is accidentally used. Cu-IUD can be inserted up to 5 days after the *first episode* of UPSI or if necessary up to 5 days after the *expected date of ovulation* (Day 19 in a regular 28-day cycle).[2]
Postpartum (in breastfeeding or non-breastfeeding women)				**Clarification:** EC is not required if UPSI or barrier method failure occurs <3 weeks pospartum. UPA and LNG are indicated from 3 weeks postpartum. Emergency Cu-IUD is indicated from 4 weeks postpartum. **Clarification**: Breastfeeding is not recommended for 1 week after taking UPA since it is excreted in breast milk. Breast milk should be expressed and discarded during that time.[5]
a) <3 weeks	NA	NA	NA	
b) 3 to <4 weeks	3	1	1	
c) ≥4 weeks	1	1	1	
Past ectopic pregnancy	1	1	1	**Clarification:** Women using contraception have a lower risk of ectopic pregnancy overall compared to women not using contraception. There does not appear to be an increased risk of ectopic pregnancy following use of Cu-IUD as EC,[6] UPA[7] or LNG[8].
Smoking	1	1	1	

UKMEC	Definition of category
Category 1	A condition for which there is no restriction for the use of the method
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable
Category 4	A condition which represents an unacceptable health risk if the method is used

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CONDITION *See additional comments at end of section	CATEGORY			CLARIFICATION/EVIDENCE
	Cu-IUD	UPA	LNG	
Obesity	1	1	1	**Evidence:** A review by the European Medicines Agency determines that data available are too limited and not robust enough to conclude with any certainty that contraceptive effect is reduced with increased body weight. The Agency's Committee for Medicinal Products for Human Use recommends that LNG and UPA could continue to be used in women of all weights as the benefits are considered to outweigh the risk.[9]
Hypertension	1	1	1	
Known dyslipidaemias	1	1	1	
Venous thromboembolism (VTE)* Current VTE (on anticoagulants)	2	2	2	**Clarification:** VTE includes DVT and PE.
History of severe CVD complications (Includes ischaemic heart disease, cerebrovascular attack, or other thromboembolic conditions)	1	1	1	**Clarification:** There is no evidence that UPA or LNG increase the risk of CVD.
Headaches	1	1	1	**Clarification:** Headache is a common condition affecting women of reproductive age.
Gestational trophoblastic disease (GTD)				
a) Undetectable hCG levels	1	1	1	**Clarification:** Includes hydatidiform mole (complete and partial) and gestational trophoblastic neoplasia.
b) Decreasing hCG levels	3	1	1	
c) Persistently elevated hCG levels or malignant disease	4	1	1	

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CONDITION *See additional comments at end of section	CATEGORY			CLARIFICATION/EVIDENCE
	Cu-IUD	UPA	LNG	
Breast conditions				
Breast cancer				**Clarification:** Although the prognosis of women with breast cancer may be affected by hormonal methods of contraception, the benefit of oral EC is considered to outweigh risks.
a) Current breast cancer	1	2	2	
b) Past breast cancer	1	2	2	
Uterine fibroids*				
a) Without distortion of the uterine cavity	1	1	1	
b) With distortion of the uterine cavity	3	1	1	
Anatomical abnormalities*				
a) Distorted uterine cavity	3	1	1	**Clarification:** Includes any congenital or acquired uterine abnormality distorting the uterine cavity in a manner that is incompatible with IUC insertion.
b) Other abnormalities	2	1	1	**Clarification:** Includes cervical stenosis or cervical lacerations not distorting the uterine cavity or interfering with IUC insertion.
Inflammatory bowel disease (including Crohn's disease and ulcerative colitis)	1	2	2	**Clarification:** Oral methods may be less reliable if there is significant malabsorption or small bowel resection (particularly with Crohn's disease). Oral methods are unaffected by colectomy and ileostomy.
Severe liver disease* *(including jaundice)*	1	1	1	

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	Cu-IUD	UPA	LNG	
Acute intermittent porphyria*	1	2	2	**Clarification:** Acute intermittent porphyria is a rare disorder characterised by acute attacks often precipitated by drugs. Estrogen and progestogen have been implicated. Around 1% of acute attacks are fatal. In one population study, almost half of women with porphyria used hormonal contraception but only 4.5% had associated acute attacks.[10] Combined hormonal contraception is shown to reduce attacks for some women.[11] Natural fluctuations in estrogen and progesterone appear to be associated with acute attacks more often than exogenous hormones. Women may use UPA or LNG following discussion of the risks and benefits and with clinical judgement.[12–14]
Repeated use of UPA or LNG (in the same cycle)	NA	1	1	**Clarification:** Recurrent use of EC is an indication that the woman requires further discussion about other contraceptive options. UPA or LNG can be used more than once in a cycle if clinically indicated.[1] Alternatively, a Cu-IUD can be inserted if repeated UPSI occurs up to 5 days after the first episode of unprotected sex or up to 5 days after expected date of ovulation. Frequently repeated UPA and LNG use may be harmful for women with conditions classified as Category 2, 3 or 4 for CHC or POC use.
Risk of sexually transmitted infections (STIs)	1	1	1	**Clarification:** Women thought to be at higher risk of STI from their sexual history (aged <25 years, or with a change in sexual partner or two or more partners in the last year) should be offered testing for STI. In a woman with asymptomatic chlamydia in an emergency situation (i.e. emergency contraception), the Cu-IUD could be inserted on the same day as treatment is instituted.[2]
DRUG INTERACTIONS				
Taking medication*	See section on drug interactions with hormonal contraception.			

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Additional Comments

POSTPARTUM
Breastfeeding: Although women who are fully or nearly fully breastfeeding, amenorrhoeic and <6 months postpartum can rely on LAM as an effective method of contraception, if breastfeeding frequency decreases or menstruation recurs EC may be indicated.

VENOUS THROMBOEMBOLISM
Current VTE taking anticoagulants: Care should be taken when fitting a Cu-IUD in those taking anticoagulants as there may be an increased risk of bleeding.

UTERINE FIBROIDS AND ANATOMICAL ABNORMALITIES (distorted uterine cavity)
In women with a distorted uterine cavity it may be appropriate after discussion to attempt insertion of Cu-IUD.

SEVERE LIVER DISEASE
The duration of use of UPA or LNG is less than that of regular use of POP and thus would be expected to have less clinical impact.

ACUTE INTERMITTENT PORPHYRIA
Cyclical symptoms have been found in relation to the menstrual cycle but seldom lead to acute attacks.

RISK OF SEXUALLY TRANSMITTED INFECTIONS (STIs)
Women who are thought to be at higher risk for STI based on a sexual history (age <25 years or age >25 years with a change in sexual partner or two or more partners in the last year) can be offered testing for STIs and should be given prophylactic antibiotics to prevent *Chlamydia trachomatis* at the time of Cu-IUD insertion.

DRUG INTERACTIONS
Current FSRH guidance recommends that women using liver enzyme inducers should be advised to use a Cu-IUD. If progestogen-only EC is to be used it should be given as soon as possible and within 72 hours of UPSI. In women using liver enzyme inducing drugs, two 1.5 mg LNG tablets should be taken (3 mg) as a single dose. The efficacy of LNG is not reduced by non-liver enzyme inducing antibiotics.