8th Congress of the European Society of Contraception
"A holistic approach to sexual health: is it needed, appropriate and possible"
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Report from Meet the Expert session:
" Emergency contraception (practical issues) "
Thursday 24 June 2004, 13:00-14:00

Experts: Dr. Anne Webb (UK) & Prof.Dr. Vera N. Prilepskaya (Russia)

This meeting was in a small, very full room. There were many experts but most of them were in the audience. They came from all over the world including Australia, Chile, Ecuador, France, Hungary, Ireland, Latvia, Mexico, Russia, Slovakia and Sweden. Most were clinicians but they included those working in gynecology, general practice and family planning. There was representation from the drug industry.

The aim was to get a discussion going around practical aspects and especially barriers to access to emergency contraception (EC). With this aim in mind we asked the audience some questions.

1. Are there any medical contraindications the EC, can it ever do any harm and would you ever not give it?

The answers had to be qualified because some clinicians are working within limitations applied by governments or national organisations which they do not necessarily agree with. This included ectopic pregnancy stated as an absolute contraindication in Mexico. After discussion all agreed that there were no medical contraindications to hormonal EC.

2. Is there a time when a woman may be better served by having a emergency intrauterine device (IUD)?

We decided that there is and that this would include:
- When the woman chooses to use an IUD as a long term contraceptive method
- When the woman wants the most effective EC
- When she is taking enzyme inducing drugs. (It is possible to offer a higher dose of levonorgestrel but the dose is always a guess.)
- Maybe if she is on a coumarin as the level may be affected by levonorgestrel but on the other hand an IUD is not the ideal method long term in a woman who is likely to bleed more.

Dr Prilepskaya showed the experience from her centre and reminded us that in the end EC is always preferable to an abortion.

3. Is there enough access to both hormonal and IUD methods?

In Hungary IUDs can only be inserted by gynecologists in larger centres and it is not "allowed" in nulliparous women. In Ireland there are no easily available copper IUDs and the doctors have to import them especially which adds to the cost. In Russia there are restrictions in nulliparous women or those not in stable relationships. Sweden uses mostly hormonal EC but that reflects convenience for the women and staff. IUDs are more expensive than hormonal EC in Slovakia. In Australia GPs don't tend to fit IUDs and contraceptive clinics may be a long way away and have significant waits for appointments.
Many women do not request an IUD and clinicians don't always mention it but it is important to remember that the EC IUD is at least 99.9% effective and can be fitted for at least five days after the risk, whereas the hormonal EC is only around 70-85% effective.
The group suggested that the possibility of IUD use should be incorporated into the information leaflet for hormonal EC. As it is the woman who gets pregnant it is she who needs the information and to have the choice of what is the best decision for her.
Where an IUD is not acceptable or available a Scottish group member reminded us that hormonal EC will not do any harm and may still have some effect up to five days.

If there is any delay in the attempted IUD insertion giving hormonal EC, in the interim, is considered a good idea as no one can ever guarantee an IUD fitting.
Discussion of the IUD reminded us that if there is a risk of pregnancy there is also a risk of sexually transmitted infections (STI). We discussed various options which will depend on the knowledge of local prevalence of disease and the risk assessment for any specific woman. These include:

- Test and treat at the time of fitting (ideally with Azithromycin 1g plus cover for gonorrhoea if the local prevalence warrants it)
- Test, get the result, treat if necessary and then fit. This will only work if results are available before the time limit for EC IUD fitting.
- We agreed that blanket treatment without testing was never the first choice of management. Testing was necessary as any positive results need contact tracing.

Dr Prilepskaya showed that in their experience 2.3% of women presenting for EC had suffered sexual abuse. This possibility should not be forgotten in any consultation.

A further discussion took place around the lower age limit for IUD fitting. Although all worried about fitting IUDs in very young women they did not wish to put a lower age limit as the younger the woman, or girl, the worse the consequences of a pregnancy.

4. How many times can a woman use hormonal EC?

All agreed that there were no limits to frequency of use although the more often a woman takes a risk the more likely she is to become pregnant and more effective methods should always be discussed.

5. What other issues should be discussed when issuing EC?

Items included were:

- Risk taking behaviour including alcohol, drugs, STI, abuse
- Ongoing contraception
- Any issues the woman is concerned about

We could have carried on talking and discussing for hours but we run out of time. It was a great opportunity to exchange thoughts and practices which is one of the best opportunities of any ESC meeting.

Anne Webb, 28/9/2004