

(1)

GyneFIX. The frameless intrauterine contraceptive implant--an update for interval, emergency and postabortal contraception

Br J Fam Plann 1999 Jan;24(4):149-59

Wildemeersch D, Batar I, Webb A, Gbolade BA, Delborge W, Temmerman M, Dhont M, Guillebaud J

(International Study Group on Intrauterine Drug Delivery, Dept of Ob/IGyn, University Hospital, Ghent, Belgium)

Abstract

This article reviews the clinical experience with the GyneFix intrauterine implant system for interval, emergency and post-abortion contraception. The relatively high rate of unintended pregnancies and abortions in the world signifies that greater access to contraception is necessary. Unwanted pregnancies and abortions could be avoided by widening the range of effective and acceptable contraceptive methods for use in situations where current methods are far from optimal. High effectiveness, protection against sexual transmitted infections, long duration of action, reversibility and safety are some of the most important attributes of contraceptives valued by women. The development of the frameless intrauterine device is a response to the need to develop contraceptives with high user continuation rate. GyneFix has the lowest failure rate of all copper IUDs currently available. Its performance is further optimised by the atraumatic frameless design which minimises the side effects and discomfort experienced with conventional IUDs. GyneFix could, therefore, be a useful new contraceptive option in looking at ways to reduce the number of unwanted pregnancies and induced abortions.

REVIEW, TUTORIAL

(2)

Emergency contraception: change in knowledge of women attending for termination of pregnancy from 1984 to 1996

Br J Fam Plann 1999 Jan;24(4):121-2

Gordon AF, Owen P

(Department of Obstetrics and Gynaecology, Ninewells Hospital and Medical School, Dundee, UK.)

OBJECTIVE: To compare the knowledge of emergency contraception in women attending hospital for termination of pregnancy in 1984 and 1996. **DESIGN:** A questionnaire survey. **SETTING:** Ninewells Hospital, Dundee. **SUBJECTS:** Cohorts of 100 consecutive women undergoing termination of pregnancy in 1984 and 1996. **RESULTS:** Over this 12 year period, there has been a significant improvement in the knowledge of emergency contraception. Seventy three per cent had a good knowledge of the postcoital pill in 1996 compared to 12 per cent in 1984 ($p \leq 0.0001$). There has been a significant rise in the use of condoms (60 per cent vs 32 per cent; $p \leq 0.001$) and the number of conceptions due to condom accidents (38 per cent vs eight per cent; $p \leq 0.0001$). Although most women in the 1996 cohort recognised a reason for contraceptive failure and had adequate knowledge of emergency contraception, only 17 per cent considered the possibility of pregnancy. **CONCLUSION:** Poor knowledge of postcoital contraception is no longer a major factor leading to the failure of women to obtain emergency contraception. Improved uptake in the use

of emergency contraception is likely to result from a greater awareness of the possibility of condom failure and easier availability of the postcoital pill.

JOURNAL ARTICLE

(3)

Not using contraception among women requesting abortion (IN NORWEGIAN)

Tidsskr Nor Laegeforen 1999 Jan 20;119(2):201-3

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Abstract

The aim of this survey was to examine the number of abortion applicants not using contraception at the time of conception, to shed light on the reasons for this, and to acquire information about the knowledge of postcoital anticonception in this patient group. The registered data is collected from precoded medical records at the University Hospital of Trondheim comprising 2,074 women applying for abortion in the period 1.1. 1995-15.7. 1997. The 291 applying for abortion 15.1-15.7. 1997, and who had not used contraception were given a questionnaire. 160 (55%) answered the questionnaire. During the period of 2.5 years 57.4% had not used contraception at the time of conception. The tendency of non-use has increased significantly during the last 2.5 years. Concern about sideeffects was the most common reason for not using contraceptives (36%). One third trusted the rhythm method and coitus interruptus. The postcoital pill was known by 93%; of the 61 women who had considered using it, 67% thought of it too late. To prevent unwanted pregnancies, it is important to focus on the positive health effects of oral contraception. Information efforts should especially be aimed at young and single women, who represent the majority of the non-users. The cost is no great impediment to the use of contraception. Availability of emergency contraception should be improved.

JOURNAL ARTICLE

(4)

UK accident and emergency departments and emergency contraception: what do they think and do?

J Accid Emerg Med 1999 Jan;16(1):35-8

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(Academic Department of Obstetrics and Gynaecology and Reproductive Healthcare, University of Manchester)

OBJECTIVES: A postal questionnaire survey was conducted to assess what staff in UK accident and emergency (A&E) departments thought of providing an emergency contraception service, the degree of enthusiasm in and level of provision of the service, and staff attitudes to the introduction or continuation of provision of the service. **METHODS:** A questionnaire was sent to all 560 departments providing A&E services in the UK. **RESULTS:** Of the 560 units sent questionnaires, 355 (63.4%) replied. Half the units were located in small county towns, and a quarter in large towns. Requests for emergency contraception were received by 96% of responding units, but only 57% provided treatment. Requests for emergency

contraception in 84 of these units ranged between one and 50 per month. The A&E senior house officer (SHO) and the gynaecology SHO and registrar prescribed most of the pills. Nurses were more involved in nurse led or general practitioner (GP) led units. Initial treatment only was given by 77% of providing units while the remainder also discussed subsequent contraception. Follow up was arranged with GPs by 92 units, and with family planning clinics by 66 units. Information packs were available in only 37 providing units. A total of 155 of providing units felt it was worthwhile and 56% of respondents thought emergency contraception should be provided by A&E departments. However, 91 units could identify one or more groups within the hospital who were antagonistic to provision by A&E departments, of which non-A&E medical staff formed the largest group. Over the counter availability of emergency contraception was not supported by 62% of respondents.

CONCLUSION: The results show that while the female population appears to see a need for emergency contraception services to be provided in A&E departments, there is some reluctance by UK A&E departments to provide the service. Given the current interest in approaches to reducing unplanned pregnancies, especially in teenagers, provision of emergency contraception by A&E departments requires a pragmatic approach to ensure their cooperation in providing the service when alternative sources of provision are not available.

JOURNAL ARTICLE

(5)

The effects of self-administering emergency contraception

J Nurse Midwifery 1999 Jan-Feb;44(1):82-4

Stehle K

(Elizabeth Seton Childbearing Center, New York, New York, USA)

CLINICAL TRIAL, RANDOMIZED CONTROLLED TRIAL

(6)

Provider attitudes toward dispensing emergency contraception in Michigan's Title X programs

Fam Plann Perspect 1999 Jan-Feb;31(1):39-43

Brown JW, Boulton ML

(School of Public Health, University of Michigan, Ann Arbor, USA)

JOURNAL ARTICLE

(7)

Timing of emergency contraception with levonorgestrel or the Yuzpe regimen. Task Force on Postovulatory Methods of Fertility Regulation

Lancet 1999 Feb 27;353(9154):721

Piaggio G, von Hertzen H, Grimes DA, Van Look PF

LETTER

(8)

Comparison of three single doses of mifepristone as emergency contraception: a randomised trial. Task Force on Postovulatory Methods of Fertility Regulation

Lancet 1999 Feb 27;353(9154):697-702

BACKGROUND: Mifepristone is a highly effective and well-tolerated emergency contraceptive when given in a dose of 600 mg within 72 h of unprotected coitus. We assessed whether the same effectiveness can be achieved with lower doses of mifepristone (50 mg and 10 mg) and a longer postcoital treatment period (120 h). METHODS: We undertook a multicentre, single-masked, randomised trial in 11 family-planning clinics in Australia, China, Finland, Georgia, the UK, and the USA. 1717 healthy women with regular menstrual cycles who requested emergency contraception within 120 h of unprotected coitus were randomly assigned to three treatment groups. FINDINGS: 32 women were lost to follow-up and one was pregnant before treatment. The 600 mg, 50 mg, and 10 mg groups did not differ in the proportions of pregnancies (seven [1.3%] of 559, six [1.1%] of 560, and seven [1.2%] of 565). Two pregnancies (both in the 50 mg group) were tubal. Among women without further acts of intercourse, treatment delay did not appear to influence the effectiveness. No major side-effects occurred, except a delay in the onset of next menses, significantly ($p < .001$) related to the mifepristone dose. INTERPRETATION: Lowering the dose of mifepristone sixty-fold did not decrease its effectiveness as an emergency contraceptive under typical use, though a study of this size cannot exclude differences in effectiveness up to almost three-fold. Lower doses of mifepristone were associated with less disturbance of the menstrual cycle. Thus, a dose as low as 10 mg seems preferable to the 600 mg dose.

CLINICAL TRIAL, RANDOMIZED CONTROLLED TRIAL, MULTICENTER STUDY

(9)

Emergency contraception: is it time to change method?

BMJ 1999 Feb 6;318(7180):342-3

Webb A

EDITORIAL

(10)

Emergency contraception: lack of awareness among patients presenting for pregnancy termination

J Pediatr Adolesc Gynecol 1999 Feb;12(1):11-5

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STUDY OBJECTIVE: Emergency contraception, otherwise known as postcoital contraception, refers to a group of birth control modalities that, when used after unprotected intercourse within defined time constraints, can markedly reduce the risk of a resultant unintended pregnancy. The English literature, using British and American awareness data, consistently claims that these contraceptive options are underutilized in the United States because of a lack of patient and physician awareness of their existence. The objective of this

study was to determine the level of awareness of postcoital contraceptive techniques in a population of American women who were presenting for pregnancy termination. The secondary goal was to calculate (theoretically) how many of these surgical terminations could have been prevented through the use of postcoital contraception. METHODS: A questionnaire was administered to patients presenting to an abortion clinic. It was intended to anonymously identify patient demographics and knowledge of the various emergency contraceptive options and, in hindsight, to determine what percentage of these women would have been willing candidates for one of these medical modalities. On completing the questionnaire, all patients received an emergency contraceptive information sheet for future consideration. RESULTS: Eighty-three patients completed the study. They ranged in age from 15 to 44 years (mean, 24 years). Forty-six percent of the patients were 21 years of age or younger. A total of 71% of all patients had no real knowledge of the existence of emergency contraceptive options; 26% had some limited knowledge, and only 3% had somewhat complete and valuable information. Fifty-one percent of the patients would have been appropriate, realistic, and willing candidates for at least the emergency contraceptive pill. Assuming at least a 75% effectiveness rate for the emergency contraceptive pill, 38% of the surgical pregnancy terminations performed on this population of women could have been avoided. CONCLUSION: Our data confirm that emergency contraceptive options are underutilized because of a lack of patient awareness. Contraception education, especially directed toward adolescents, should include disseminating enhanced information about postcoital contraception options.

JOURNAL ARTICLE

(11)

The risk of venous thromboembolism in users of postcoital contraceptive pills.

Contraception 1999 Feb;59(2):79-83

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Postcoital contraceptive pills (PCP) have recently been approved for use as emergency contraception in the United States. The objective of this study was to assess the risk of idiopathic venous thromboembolism (VTE) in relation to exposure to PCP, and to better quantify the risk of idiopathic VTE associated with current oral contraceptive (OC) use and pregnancy. A population-based cohort study with a nested case-control analysis was conducted using women from the General Practice Research Database. There were no women with an outcome of idiopathic VTE with current exposure to PCP. The incidence rates for various exposures were 3.0/100,000 person-years for the unexposed, 5.3/100,000 person-years for second generation OC, 10.7/100,000 person-years for third generation OC, and 15.5/100,000 person-years in pregnant (or postpartum) women. The relative risk estimates were 1.7 (95% CI 0.3-10.5) for second generation OC, 4.4 (95% CI 1.0-18.7) for third generation OC, and 6.3 (95% CI 1.2-33.5) for pregnancy. Short-term use of PCP is not associated with a substantially increased risk for developing VTE.

(12)

Pregnancy prevention using emergency contraception: efficacy, attitudes, and limitations to use

J Pediatr Adolesc Gynecol 1999 Feb;12(1):3-9

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Emergency contraception, also called postcoital contraception, is the use of hormonal or mechanical methods to prevent pregnancy after an episode of unprotected intercourse. Although a number of methods of emergency contraception exist, its use in the United States is not widespread. This report reviews studies on the efficacy of hormonal methods of emergency contraception, as well as the literature on women's and physicians' knowledge of and attitudes toward this method of preventing pregnancy. Articles were selected for this review from a MEDLINE search using the term "postcoital contraception." These studies show that a variety of hormonal regimens are effective in reducing the chance of pregnancy when administered within 72 hours of an episode of unprotected intercourse. Failure rates range from 0%-4.66%, depending on the regimen and the study, although some controversy exists about how to calculate efficacy. Recent studies indicate that mifepristone (RU486) may be more effective than other methods, with fewer side effects. However, the more significant issue surrounding emergency contraception may be the reasons for its infrequent use in this country. A number of limitations to use have been identified in the literature, including lack of knowledge of the method among patients and physicians, inadequate counseling, and fears that widespread use of emergency contraceptives would lead to less consistent use of other methods of contraception.

REVIEW, TUTORIAL

(13)

Levonorgestrel versus the "Yuzpe" regimen. New choices in emergency contraception

Can Fam Physician 1999 Mar;45:629-31

Lee SM, Dunn S, Evans MF

(Department of Family and Community Medicine, University of Toronto)

JOURNAL ARTICLE

(14)

Emergency contraception in a travel context

J Travel Med 1999 Mar;6(1):24-6

Patton PG

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This paper highlights the advantages which emergency contraception medication can offer to female travelers. It also outlines the history of emergency contraception, the methods available, and the side effects. The Yuzpe method is discussed in detail, including mode of action, side effects and effectiveness. There are no absolute contraindications, but issues such as clotting factors, migraine and teratogenicity are discussed. The availability of suitable medication in the event of failed contraception or rape could prove invaluable. Under a multitude of travel situations it may be very difficult to locate a medical practitioner who is able to provide the required medication within the crucial time frame. PMID: 10071369, UI: 99170763

TUTORIAL

(15)

Emergency contraception in a travel context

J Travel Med 1999 Mar;6(1):1-2

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Abstract:

Emergency contraception prevents pregnancy after unprotected intercourse. In his paper Peter Patton highlights the potential value of emergency contraception for women who travel. In addition to the common indications for emergency contraception-unprotected intercourse and accidents with condoms-Patton cites particular difficulties that travelers might encounter, gastrointestinal upset; changes in time zones; changes in routine; difficulty with looking after female barrier methods and rape. An additional problem which we see not infrequently in our clinics is theft. Women tend to keep contraceptives in their handbag and if this is stolen so is their contraception. Emergency contraception is underused because it must be taken within 72 hours of intercourse. This is a problem which all women face but one which is particularly relevant for travelers who may be unable to find a doctor. Patton points out that language and cultural barriers may prevent access to emergency contraception. What he does not say is that in the majority of countries there is no licensed method of emergency contraception available and although alternatives exist many doctors are ignorant of these or, for a variety of reasons, refuse to prescribe. Furthermore-and in contrast to the evidence quoted by Patton-recent data from the World Health Organization (WHO)¹ suggests that the Yuzpe regimen of emergency contraception, on which Patton bases his discussions, may be less effective as time passes. In the WHO study the regimen prevented 77% of expected pregnancies if it was used within 24 hours of intercourse but only 36% when used between 25 and 48 hours and 31 % after 48 and before 72 hours. For this reason alone it makes sense for women to have supplies of emergency contraception available before it is required. Patton does not mention the value of combined oral contraceptive pills as a substitute for the Yuzpe regimen of emergency contraception. In 1997, aware that it might take some time before a licensed method became available in the USA, the Food and Drug Administration² issued advice to doctors listing which currently available brands of oral contraceptive pill could be used as emergency contraception and how to use them. Advice of this sort to travelers would be particularly useful since the pill is available in most countries, and in some of them a doctor's prescription is not necessary. Possibly better than the Yuzpe regimen in terms of efficacy and certainly better in terms of side effects, levonorgestrel alone (0.75 mg twice, 12 hours apart) is already marketed in some Eastern European and Asian countries.¹ It is likely to become available soon in Western Europe and, like Yuzpe, can be 'home-made' using supplies of levonorgestrel progestogen-only pills (although rather a lot of tablets need to be taken!). Patton states correctly that there are no contraindications to the Yuzpe regimen yet many doctors are still concerned about cardiovascular risks (particularly venous thromboembolism) which they extrapolate from long term use of the contraceptive pill. Levonorgestrel alone is clearly an even safer preparation. Mifepristone is probably more effective, safer and has fewer side effects than either Yuzpe or levonorgestrel.³ It is widely available as an emergency contraceptive in China-an increasingly popular travel destination. It is likely that Patton's article will upset some readers. The topic of emergency contraception is guaranteed to raise a variety of issues. Many doctors are concerned that easy access to emergency contraception will discourage the use of more reliable methods and particularly condoms which are the only method conferring protection against sexually transmitted infections (STIs). This is particularly relevant to women traveling in parts of the world where STIs and particularly HIV and AIDS are common. However, the great majority of women travelers are well aware of these risks and are already extremely concerned to avoid infection.

TUTORIAL,REVIEW

(16)

Updated estimates of the effectiveness of the Yuzpe regimen of emergency contraception.

Contraception 1999 Mar;59(3):147-51

Trussell J, Rodriguez G, Ellertson C

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Abstract:

The purpose of this study was to provide revised estimates of the effectiveness of the Yuzpe method of emergency contraception. Through a literature search, we identified eight studies that present the number of women treated and outcome of treatment by cycle day of unprotected intercourse relative to expected day of ovulation. Using five sets of external estimates of conception probabilities by cycle day of intercourse among women not using contraception, we assessed the effectiveness of the Yuzpe regimen. The 45 estimates of effectiveness, based on eight separate studies and the eight studies combined and five different sets of conception probabilities by cycle day, ranged from a low of 56.4% to a high of 89.3%. Our preferred point estimate is that the Yuzpe regimen reduces the risk of pregnancy by 74.1%, with a 95% confidence interval extending from 62.9% to 79.2%. True effectiveness is likely to be > 74% because treatment failures (observed pregnancies) include women who were already pregnant when treated and women who became pregnant after being treated.

REVIEW, TUTORIAL

(17)

Safety and effectiveness of hormonal postcoital contraception: a prospective study.

Eur J Contracept Reprod Health Care 1999 Mar;4(1):27-33

Espinosa JJ, Senosiain R, Aura M, Vanrell C, Armengol J, Cuberas N, Calaf J

(Department of Obstetrics and Gynecology, Universitat Autònoma, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain.)

OBJECTIVE: The aim of this study was to evaluate the demographic characteristics of the population attending our hospital requesting postcoital contraception and to determine the effectiveness of the method and its side-effects. **METHODS:** A total of 503 women asking for postcoital contraception were included in a prospective open trial. After filling in a questionnaire dealing with demographic and contraceptive data, we prescribed an ethinylestradiol-levonorgestrel combination (100 micrograms/500 mg for two doses 12 h apart). **RESULTS:** Only 487 women were available for analysis of demographic data. A further 77 were excluded because they presented irregular menstrual cycles and 55 cases were lost for follow-up. Mean age was 22.6 +/- 5.25 years and 35.9% of cases came to the center within the first 5 h after unprotected intercourse. Only 18.8% had previously asked for postcoital contraception. Breakage of condom was the most common reason for request (81.9%). Two pregnancies occurred in the remaining 355 women. According to Dixon's method 15.5 pregnancies should be expected being the overall efficacy of 87.14%. There were no serious adverse effects. Nausea and vomiting (16.33%) were the most prevalent and 59% of the users menstruated at the expected time whilst menses were delayed in 6% of the cases. **CONCLUSION:** The combination of ethinylestradiol and levonorgestrel in low doses is an effective and safe method of postcoital contraception.

(18)

Emergency contraception.

J Am Med Womens Assoc 1999 Spring;54(2):101-2

Comment on: J Am Med Womens Assoc 1998;53(5 Suppl 2):233-7

Gibbs JN

COMMENT, LETTER

(19)

Knowledge, attitudes, and practices regarding emergency contraception among nurses and nursing students in two hospitals in Nairobi, Kenya.

Contraception 1999 Apr;59(4):253-6

Gichangi PB, Karanja JG, Kigonde CS, Fonck K, Temmerman M

(Department of Obstetrics and Gynecology, University of Nairobi, Kenya. medmicro@ken.healthnet.org)

Abstract:

A cross-sectional descriptive study on knowledge, attitudes, and practice about emergency contraception (EC) was conducted among nurses and nursing students using a self-administered questionnaire. One-hundred-sixty-seven qualified nurses and 63 nursing students completed the questionnaire. Over 95% listed at least one regular contraceptive method but only 2.6% spontaneously listed EC as a contraceptive method, whereas 48% of the respondents had heard of EC. Significantly more nursing students than qualified nurses were familiar with EC. Knowledge about the types of EC, applications, and side effects was poor and 49% of the respondents considered EC as an abortifacient. Of those familiar with EC, 77% approved its use for rape victims and 21% for adolescents and schoolgirls. Only 3.5% of all respondents had personally used EC in the past, 23% of those familiar with EC intend to use it in the future, whereas 53% intend to provide or promote it. The view that EC was abortifacient negatively influenced the decision to use or provide EC in the future. The present findings suggest that the level of knowledge of EC is poor and more information is needed. These findings indicate the potential to popularize emergency contraception in Kenya among nurses and nursing students.

(20)

Integrated clinical service for sexual assault victims in a genitourinary setting.

Sex Transm Infect 1999 Apr;75(2):116-9

Bottomley CP, Sadler T, Welch J

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BACKGROUND: Reported sexual assault is increasing, and the diverse immediate and longer term needs of the victim are usually met by exposure to a number of healthcare professionals often in different locations, involving delays and travel, increasing the trauma for the victim. **OBJECTIVES:** To set up a centre to address the immediate and longer term needs of the sexual assault victim and review issues arising during the development of the service. **METHODS:** Description of setting up the service in the genitourinary medicine department of Kings College Hospital, south London, and the aspects of care offered. **RESULTS:** The number of victims referred by police increased from 15 in 1992 to 58 in 1996. In 1996, 55 female and three male victims were seen. 23 different police stations brought victims for examination; mean age of the victim was 27 years (range 14-60), median time between assault and examination was 22 hours (range 3 hours-3 months); 23% had genital injuries, 59% had other physical injury, and 11% needed further hospital care. 71% accepted

screening for sexually transmitted infection (STI), 21% had an STI diagnosed, 16% of the women required emergency contraception, 26% received prophylactic antibiotics, and 58% saw a health adviser. 70% had a follow up appointment arranged of which 50% attended. CONCLUSION: The high uptake of STI screening, emergency contraception, health adviser consultation, and follow up supports the concept of a comprehensive integrated system to meet the disparate needs of the victim while still obtaining the necessary forensic evidence. The wide catchment area of service users indicates gaps in services available for the assault victim. Earlier genitourinary involvement after sexual assault is becoming increasingly pertinent in relation to HIV prophylaxis.

(21)

Emergency contraception: The sooner the better (IN NORWEGIAN)

Tidsskr Nor Laegeforen 1999 Apr 30;119(11):1572

Aavitsland P

(22)

Emergency contraception.

Int J Clin Pract 1999 Apr-May;53(3):199-204

Sarkar NN

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Abstract:

Emergency contraception means preventing pregnancy after unprotected sexual intercourse. This is also called postcoital contraception (PCC) or the 'morning-after pill'. High doses of oestrogen or progestogen or a combination of both may be used as PCC up to 72 hours after unprotected intercourse. The use of mifepristone as emergency contraception has also proved promising. Some women use emergency contraception, but there are many who do not know much about it. Users, providers and other health professionals need to be educated about this method. Emergency contraception does not fall within the ambit of abortion law, yet its acceptability depends on the legal, cultural and religious consideration of most countries. This method is safe and effective and could be used occasionally to prevent unwanted pregnancy.

REVIEW, TUTORIAL

(23)

Emergency contraception and retinal vein thrombosis.

Br J Ophthalmol 1999 May;83(5):630-1

Comment on: Br J Ophthalmol 1998 May;82(5):538-42

Lake SR, Vernon SA

COMMENT, LETTER

(24)

Statistical evidence about the mechanism of action of the Yuzpe regimen of emergency contraception.

Obstet Gynecol 1999 May;93(5 Pt 2):872-6

Trussell J, Raymond EG

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OBJECTIVE: To determine whether published statistical evidence about the effectiveness of the Yuzpe regimen of emergency contraception provides insight about its mechanism of action. **DATA SOURCES:** We searched the literature for studies that present information on the effectiveness of the Yuzpe regimen, on the probability of conception by menstrual cycle day, or on the occurrence of ovulation in women treated with the regimen. Searches of the electronic databases MEDLINE, POPLINE, EMBASE, and BIOSIS were supplemented by scrutiny of the bibliographies of all papers identified through the electronic search. **METHODS OF STUDY SELECTION:** We identified a review of the effectiveness of the Yuzpe regimen based on all seven clinical trials that present the number of women treated on each cycle day and the outcome of each treatment; this review also provided external estimates of the probability of conception by cycle day of unprotected intercourse from two other clinical studies. We identified three clinical studies of ovulation after treatment with the Yuzpe regimen. We included all identified studies in our analysis. **TABULATION, INTEGRATION, AND RESULTS:** We compared 40 estimates of the actual effectiveness of the Yuzpe regimen with the maximum theoretical effectiveness that could be obtained if the regimen worked only by preventing or delaying ovulation. In the overwhelming majority of these comparisons, the former exceeded the latter. **CONCLUSION:** The Yuzpe regimen could not be as effective as it appears to be if it worked only by preventing or delaying ovulation.

REVIEW, TUTORIAL

(25)

Emergency contraception.

Nurse Pract 1999 May;24(5):20

Comment on: Nurse Pract 1999 Feb;24(2):44-8, 54, 56-7; quiz 58-9

Rosenberg A

COMMENT, LETTER

(26)

Contraception in emergencies. [Article in Hebrew]

Harefuah 1999 Jun 1;136(11):874-7

Mashiach R, Seidman DS

REVIEW, TUTORIAL

(27)

Emergency contraception.

Ceylon Med J 1999 Jun;44(2):60-2

Gunasekera PC

UNFPA, Colombo 7.

REVIEW, TUTORIAL

(28)

Review of newer contraceptive agents.

Cleve Clin J Med 1999 Jun;66(6):358-66

Qureshi M, Attaran M

(Department of General Internal Medicine, Cleveland Clinic Foundation, OH 44195, USA)

Abstract:

Advances in contraceptive technology have made birth control more effective, convenient, and safe. We review the newer products and some under development, including the latest oral contraceptives, injectable progesterone, subdermal progestin implants, progesterone-releasing IUDs, emergency contraception, and male contraception.

REVIEW, TUTORIAL

(29)

Knowledge and practice of emergency contraception among Nigerian youths.

Int J Gynaecol Obstet 1999 Jul;66(1):31-2

Arowojolu AO, Adekunle AO

(Obstetrics and Gynecology Department, University College Hospital, Ibadan, Nigeria.)

(30)

Barriers to the use of IUDs as emergency contraception.

Br J Fam Plann 1999 Jul;25(2):61-8

Reuter S

(Community Health Care Service North Derbyshire NHS Trust, Saltergate Health Centre, Chesterfield S41 1SX, UK.)

Abstract:

The intrauterine contraceptive device (IUD) is a very effective form of emergency contraception (EC). This author hypothesised that IUDs are an underused method and determined to evaluate potential barriers to IUD use. A postal survey of 100 family planning doctors and 100 general practitioners was conducted in Trent Region during March 1998 with a 70 per cent response rate. Lack of time was the most important factor that influenced doctor's decisions not to offer IUDs to the majority of women requesting emergency contraception. Most doctors registered concern about the risk of pelvic inflammatory disease. Misconceptions and a lack of accurate information contributed to participants reluctance to discuss IUDs as emergency contraception. Lack of time in consultations is a well-recognised issue in general practice. The risk of sexually transmitted infections is a nationwide concern, but is difficult to address without accurate data on the prevalence of the most common pathogens. Considerable effort would be required to increase doctors' knowledge and willingness to offer IUDs routinely to women requesting emergency contraception.

(31)

Knowledge of emergency contraception amongst female patients attending a department of genitourinary medicine.

Br J Fam Plann 1999 Jul;25(2):58-62

Mann MC, Radcliffe KW, Basarab M

(City Hospital NHS Trust, Dudley Road, Birmingham B18 7QH, UK.)

Abstract:

The aim of the study was to assess the knowledge of emergency contraception amongst new female patients attending an inner-city department of genitourinary medicine. Information was also sought about use of regular contraception and demography. Three hundred and ninety nine questionnaires were suitable for analysis. Half of the sample answered that the latest a woman could take emergency contraception after unprotected sex was three days. None of the sample knew that emergency contraception could be obtained up to five days. Twenty nine per cent of the sample reported sex without contraception during the menstrual cycle preceding attendance. Women who had ever used regular contraception in the past were statistically less likely to have reported unprotected sex in the menstrual cycle preceding attendance ($p=0.000068$). Professional women were statistically less likely to have reported unprotected sex in the menstrual cycle preceding the clinic visit. Fourteen per cent of the sample had genital warts at this first clinic visit, 10 per cent had Chlamydia trachomatis, seven per cent had herpes simplex infection, six per cent had gonococcal infection and five per cent had trichomonal infection. Women who reported unprotected sex during the preceding menstrual cycle were not statistically more likely to have a sexually transmitted infection at this first clinic visit. A large number of women attending departments of genitourinary medicine are at risk of both pregnancy and also sexually transmitted infection. Staff working in all areas of sexual health need to have a good knowledge of both contraception and sexually transmitted infections in order to educate the clients on both aspects of unprotected sex.

(32)

Easy access to emergency contraception does not make it the contraceptive of choice.

BMJ 1999 Jul 10;319(7202):D

Questionnaire study of use of emergency contraception among teenagers.

BMJ 1999 Jul 10;319(7202):91

Kosunen E, Vikat A, Rimpela M, Rimpela A, Huhtala H

(Department of General Practice, Medical School, University of Tampere, PO Box 607, FIN-33101 Tampere, Finland.)

(33)

Prescribing and managing oral contraceptive pills and emergency contraception for adolescents.

Pediatr Clin North Am 1999 Aug;46(4):695-718

Gold MA

Department of Pediatrics, Children's Hospital of Pittsburgh, University of Pittsburgh, School of Medicine, Pennsylvania, USA. magold+@pitt.edu

Abstract:

Combination OCPs are safe and effective ways to prevent unintended adolescent pregnancy if they are used properly. Numerous noncontraceptive benefits of OCPs can bolster continued combination OCP use. Progestin-only OCPs are an option, particularly for young women with medical contraindications to taking estrogens; however, because of their lower efficacy, progestin-only pills are not the first choice for oral contraception for adolescents. Health care providers can give young women a second chance to prevent unintended pregnancy by improving their access to emergency contraception through educating and counseling about emergency contraception at all office visits, by prescribing emergency contraceptive pills in advance, or by prescribing emergency contraceptive pills over the telephone.

REVIEW, TUTORIAL

(34)

Condom failures in women presenting for abortion.

N Z Med J 1999 Aug 27;112(1094):319-21

Sparrow MJ

Parkview Clinic, Wellington Hospital, Capital Coast Health Ltd.

Abstract:

AIMS: To document the main reasons for condom failure in women presenting for first trimester termination of pregnancy. METHODS: From 1990-97 an audit was carried out, on the 3283 cases personally operated on by the author, using the information routinely obtained during pre-operative counselling. RESULTS: Two sets of figures were obtained. The first (minimum figures) were restricted to those who used condoms on every occasion of coitus (746 or 22.7% of all women seen). The second (maximum figures) included all of these plus those who did not use condoms on every occasion or who used condoms in conjunction with another method (1494 or 45.5% of all women seen). In this expanded group, there was no obvious cause for the failure in 446 (29.9% of condom users). The main reason for failure was not using condoms every time (736 or 49.3% of condom failures). Leakage of semen occurred in 321 cases (21.5% of condom failures) and 104 of these had used emergency contraception which had also failed (7.0% of condom failures). Condoms failed more often in women under 25 years of age. CONCLUSIONS: There is a need for better education on correct condom use and improved availability of emergency contraception. There is also a need for greater standardisation in reporting contraceptive failure.

(35)

Practice tips. Emergency contraception.

Can Fam Physician 1999 Sep;45:2063

Greiver M

(36)

UK accident and emergency departments and emergency contraception.

J Accid Emerg Med 1999 Sep;16(5):391

Comment: on: J Accid Emerg Med 1999 Jan;16(1):35-8

McGlone R

COMMENT, LETTER

(37)

Bundling a pregnancy test with the Yuzpe regimen of emergency contraception.

Obstet Gynecol 1999 Sep;94(3):471-3

Grimes DA, Raymond EG

Family Health International, Research Triangle Park, North Carolina 27709, USA. dgrimes@fhi.org

Abstract:

The recent United States Food and Drug Administration approval of a commercial kit containing the Yuzpe regimen for emergency contraception is a welcome event. Unlike emergency contraceptive pills sold in other countries, however, the United States product has a pregnancy test bundled with the pills. The test could identify existing pregnancies and avoid unnecessary use of the pills, although any protection against lawsuits alleging injury to an embryo is speculative. Conversely, no major medical organization recommends routine pregnancy testing before using emergency contraceptive pills. The test might stigmatize the Yuzpe regimen as being dangerous to an embryo. Difficulty in understanding the pregnancy test instructions could, paradoxically, deter some women from using the pills after having bought them. The bulky size of the pregnancy test reagent stick makes the package indiscreet, and the test adds unnecessary cost to emergency contraception. The greatest usefulness of the test could be to confirm or exclude a pregnancy several weeks after taking the pills, rather than before. If bundling an unnecessary test with emergency contraception is the only way to bring this useful product to the United States market, then the public health benefits could outweigh the disadvantages. However, this approach sets a worrisome precedent and further isolates the United States from the international medical community.

(38)

Women's experiences of obtaining emergency contraception: a phenomenological study.

J Clin Nurs 1999 Sep;8(5):601-9

Bell T, Millward J

Lisson Grove Health Centre, Plymouth, UK.

Abstract:

Emergency contraception (EC) has been available since 1984 but has been labelled the 'best kept secret' (Winfield, 1995). Because EC was originally termed 'the morning after pill', many people interpreted this literally and missed an opportunity to use the method. More recent publicity has dropped this term and emphasized that the method is effective up to 72 h after unprotected intercourse or contraceptive failure (Burton & Salvage, 1990). Uptake of EC has steadily increased since 1985 but there is still evidence that younger women in particular are least aware of its existence.

(39)

Emergency contraception.

Ceylon Med J 1999 Sep;44(3):142-3; discussion 143-5

Comment on: Ceylon Med J 1999 Jun;44(2):60-2

Wijesinghe PS

COMMENT

(40)

Emergency contraception.

Ceylon Med J 1999 Sep;44(3):142; discussion 143-5

Comment on: Ceylon Med J 1999 Jun;44(2):60-2

Paranavitane S

COMMENT

(41)

Women's experience and satisfaction with emergency contraception.

Fam Plann Perspect 1999 Sep-Oct;31(5):237-40, 260

Harvey SM, Beckman LJ, Sherman C, Petitti D

Pacific Institute for Women's Health, Los Angeles, CA, USA.

CONTEXT: If any new contraceptive technology is to become a viable option for decreasing unintended pregnancies, women must be willing to use the method and find it acceptable. However, because emergency contraceptive pills have not been widely used, very little is known about this method's acceptability.

METHODS: Telephone interviews were conducted with 235 women who had received emergency

contraceptive pills through a demonstration project at 13 Kaiser Permanente medical offices in San Diego to assess women's experience and satisfaction with the pills. RESULTS: More than two-thirds of the women (70%) were using a contraceptive method prior to their need for emergency contraception, and 73% of these users were relying on condoms. When asked about the situation that led to unprotected intercourse, 45% reported that their condom broke or slipped, while 23% said they had had unplanned sex. More than three-quarters of the sample (81%) experienced at least one side effect. The overwhelming majority were satisfied with emergency contraceptive pills (91%) and would recommend them to friends and family members (97%). Just one-quarter of the sample (28%) believed that emergency contraceptive pills should be dispensed over the counter, and an even lower proportion agreed that they should be available from vending machines (6%). CONCLUSIONS: Because women were overwhelmingly accepting of emergency contraceptive pills, found them easy to use and did not intend to substitute them for regular contraceptive use, this new method is an important addition to the contraceptive options available to women, providing a way to prevent pregnancy after unprotected intercourse or method failure.

(42)

Family planning training in Maryland family practice and obstetrics/gynecology residency programs.

J Am Med Womens Assoc 1999 Fall;54(4):208-10

Cheng D

(Office of Maternal Health and Family Planning, Maryland Department of Health and Mental Hygiene in Baltimore, USA.)

OBJECTIVE: To examine the extent of family planning and abortion training in Maryland family practice (FP) and obstetrics/gynecology (OB) residency training programs. METHODS: All final-year residents in every FP and OB residency training program in Maryland were asked in 1998 how many cases (0, 1-10, > 10) of ten methods of contraception and abortion they had managed. RESULTS: Seventy-five percent (55) of the 73 residents responded. Fifty percent of FP residents had never inserted an intrauterine device (IUD), 43% had never inserted an implant (Nor-plant), 37% had never prescribed emergency contraceptive pills, and 30% had never fitted a diaphragm. Ninety-seven percent of FP residents had no experience with elective termination of pregnancy, and 83% had no experience with sterilization. Twenty percent of OB residents had never inserted an IUD, 16% had never inserted implants or prescribed emergency contraceptive pills, 20% had never fitted a diaphragm, and 36% had no experience in elective termination of pregnancy. Not one FP resident had inserted or fitted more than ten IUDs, implants, diaphragms, or cervical caps. Except for oral and injectable contraception, the majority of OB residents had not managed more than ten cases of any other reversible contraceptive method: 80% had not inserted more than ten IUDs, 72% had not inserted more than ten implants, 88% had not fitted more than ten diaphragms, and 100% had not fitted more than ten cervical caps. CONCLUSION: These survey results indicate a need for more formal instruction in most contraceptive methods for OB and FP residency programs in Maryland. This study concurs with previous national studies showing deficits in family planning training.

(44)

Establishing an educational programme for nurses to supply emergency hormonal contraception (combined method) to protocol.

Br J Fam Plann 1999 Oct;25(3):118-21

Brittain D

(Department of Midwifery Studies, University of Central Lancashire, Preston, Lancashire, UK.)

Abstract:

This paper gives an account of an innovative educational programme developed by the Department of Midwifery Studies at the University of Central Lancashire (UCLAN) in 1995. The North West Regional Health Authority (NWRHA) approached the Department of Midwifery Studies to develop an educational programme for family planning nurses to supply the combined method of emergency hormonal contraception (EHC) under protocol when a doctor was not present. The purpose was to increase the availability and accessibility of EHC for young people in the North West region. The 3-day programme was designed to complement previous ENB 901/900 training, and also to provide the nurses with the specific skills and knowledge required to undertake this new role. One hundred and thirty-nine nurses from the North West area attended the programme between 1995-1998. Students were assessed both theoretically and clinically. Extending the role of family planning nurses to supply EHC gives purchasers and providers of sexual health care the potential to offer a wider range of accessible services. The recently published interim Crown Report 1 on the supply and administration of medicines under group protocols states that protocols should specify clear arrangements for professional responsibility and accountability. Appropriate training is essential to ensure that the extended role of the nurse in family planning is fully understood.

(45)

Issue of emergency hormonal contraception through a casualty department in a community hospital.

Br J Fam Plann 1999 Oct;25(3):105-9

Heard-Dimyan J

Powys Health Care Trust, Brecon, Wales.

Abstract:

The results of this survey show that sexually active women seeking emergency hormonal contraception are finding that a casualty department in a community hospital offers convenience, confidentiality and accessibility above all else. There is a growing tendency for those registered with the local practice to prefer to come to the hospital for post-coital contraception, even though casualty nurses are not family planning qualified. This applies especially to the under twenties. More needs to be done in persuading patients that ongoing contraception should be addressed. To this end, if casualty departments are the preferred outlets in the rural communities, then nurses need further training. All providers of emergency contraception in rural areas need to be aware that offering such a service by well trained RGNs working to a protocol could reduce the incidence of unintended conceptions amongst teenagers. At the same time, every effort has to be made to increase awareness of the availability of emergency hormonal contraception by advertising the sources of contraceptive advice, which could soon include pharmacists.

(46)

Pharmacists' concerns and perceived benefits from the deregulation of hormonal emergency contraception (HEC).

Br J Fam Plann 1999 Oct;25(3):100-4

Blackwell D, Cooper N, Taylor G, Holden K

(School of Health Sciences, The University of Sunderland, Sunderland, Tyne & Wear, UK.)

OBJECTIVE: To ascertain pharmacists' views, assess willingness for involvement and delineate individual perceived competence in the supply of deregulated hormonal emergency contraception (HEC). **DESIGN:** Cross-sectional postal questionnaire utilising closed, open and Likert-scale questions. **SUBJECTS:** Three thousand nine hundred and ninety-nine registered pharmacists abstracted from the mailing list of the Royal Pharmaceutical Society of Great Britain. **RESULTS:** In total 1543 (38.6%) questionnaires were returned and analysed. Overall 1165 (75.5%) of pharmacists stated their willingness to be involved in the deregulated supply of HEC. However, pharmacists identified the need for specific training before effective deregulation should take place. Overall, 616 (39.9%) of respondents felt individually competent to supply deregulated HEC with a positive association between perceived competence and willingness to supply deregulated HEC ($p < 0.05$). Pharmacists perceive the major benefits of deregulation to be a reduced unwanted pregnancy rate and a subsequent reduced abortion rate. They perceive that deregulation would allow quicker and less restricted access to HEC by clients, facilitating an increased overall supply of HEC. Pharmacists express a number of concerns, tempering their collective desire to see HEC deregulation. The majority of these concerns related to safeguarding clients and the possible adverse public health effects associated with the possible reduced use of barrier methods of contraception. **CONCLUSIONS:** Most pharmacists would be willing to supply HEC if it were deregulated to 'pharmacy only' from 'prescription only' medicine status. Although concerns were raised, these were mainly related to safety issues, with few pharmacists identifying moral and ethical barriers to deregulation. For effective deregulation to occur issues of professional competence need to be addressed.

(47)

Hormonal emergency contraception: moving over the counter?

J Clin Pharm Ther 1999 Oct;24(5):313-5

Wearn AM, Gill PS

(Department of Primary Care and General Practice, The Medical School, University of Birmingham, U.K. a.m.wearn@bham.ac.uk)

(48)

Emergency contraception in Mexico City: what do health care providers and potential users know and think about it?

Contraception 1999 Oct;60(4):233-41

Langer A, Harper C, Garcia-Barrios C, Schiavon R, Heimbürger A, Elul B, Delgado SR, Ellertson C

Population Council, Mexico City, Mexico.

Abstract:

Emergency contraception promises to reduce Mexico's high unwanted pregnancy and unsafe abortion rates. Because oral contraceptives are sold over-the-counter, several emergency contraceptive regimens are already potentially available to those women who know about the method. Soon, specially packaged emergency contraceptives may also arrive in Mexico. To initiate campaigns promoting emergency contraception, we interviewed health care providers and clients at health clinics in Mexico City, ascertaining knowledge, attitudes, and practices concerning the method. We found limited knowledge, but nevertheless cautious support for emergency contraception in Mexico. Health care providers and clients greatly overestimated the negative health effects of emergency contraception, although clients overwhelmingly reported that they would use or recommend it if needed. Although providers typically advocated medically controlled distribution,

clients believed emergency contraception should be more widely available, including in schools and vending machines with information prevalent in the mass media and elsewhere.

(49)

Emergency contraception in Nairobi, Kenya: knowledge, attitudes and practices among policymakers, family planning providers and clients, and university students.

Contraception 1999 Oct;60(4):223-32

Muia E, Ellertson C, Lukhando M, Flul B, Clark S, Olenja J

Population Council, Nairobi, Kenya.

Abstract:

To gauge knowledge, attitudes, and practices about emergency contraception in Nairobi, Kenya, we conducted a five-part study. We searched government and professional association policy documents, and clinic guidelines and service records for references to emergency contraception. We conducted in-depth interviews with five key policymakers, and with 93 family planning providers randomly selected to represent both the public and private sectors. We also surveyed 282 family planning clients attending 10 clinics, again representing both sectors. Finally, we conducted four focus groups with university students. Although one specially packaged emergency contraceptive (Postinor levonorgestrel tablets) is registered in Kenya, the method is scarcely known or used. No extant policy or service guidelines address the method specifically, although revisions to several documents were planned. Yet policymakers felt that expanding access to emergency contraception would require few overt policy changes, as much of the guidance for oral contraception is already broad enough to cover this alternative use of those same commodities. Participants in all parts of the study generally supported expanded access to emergency contraception in Kenya. They did, however, want additional, detailed information, particularly about health effects. They also differed over exactly who should have access to emergency contraception and how it should be provided.

(50)

Emergency contraception: implications for nursing practice.

Nurs Stand 1999 Nov 3-9;14(7):38-43; quiz 44

Quinn S

School of Health, Biological and Environmental Sciences, Middlesex University.

Abstract: Emergency contraception is often misunderstood by the general public and nurses alike. This article outlines information about methods of post-coital contraception that all nurses need to provide appropriate health advice to women in any nursing setting.

(51)

Update on the use of oral contraceptive pills for emergency contraception.

Med Health R I 1999 Nov;82(11):410-1

Flanagan PJ

Division of Adolescent Medicine, Rhode Island Hospital, Providence 02903, USA.

PFlanagan@Lifespan.org

(52)

Emergency contraception: is it always justifiable?

J Pediatr Adolesc Gynecol 1999 Nov;12(4):230-2

Comment on: J Pediatr Adolesc Gynecol 1999 Nov;12(4):229-30

Stradtman EW Jr

COMMENT

(53)

In support of emergency contraception.

J Pediatr Adolesc Gynecol 1999 Nov;12(4):229-30

Comment on: J Pediatr Adolesc Gynecol 1999 Nov;12(4):230-2

Gold MA

COMMENT

(54)

Emergency contraception: an anomalous position in the family planning repertoire?

Soc Sci Med 1999 Nov;49(10):1409-17

Ziebland S

(ICRF General Practice Research Group, University of Oxford Division of Public Health & Primary Health Care, Institute of Health Sciences, Headington, UK.) sue.ziebland@dphpc.ox.ac.uk

Abstract:

Emergency contraception (EC) can be used up to 72 h after sex to prevent pregnancy. Internationally there is wide variation in the availability of EC. In the USA it has only recently (1997) won approval from the FDA, while the UK and New Zealand have seen calls for over the counter availability. In recent years surveys, editorials and opinion pieces in medical journals have pointed out that increased access to EC could help to tackle the unwanted pregnancy rate, especially among teenagers, and concluded that lack of knowledge of EC is the major barrier to use. However, women in a UK study have expressed concerns that it is not safe to use the method repeatedly and cited general practitioners (GPs) as one of the sources of this belief, which contradicts the professional guidelines and the rationale for de-regulation. A subsequent study sought to seek the views of GPs about prescribing EC and explored reasons for the gap between the views of women using UK family planning services, GPs and professionals at the public policy level. Data from two studies are presented. In the first study, 53 women seeking emergency contraception were interviewed at two family planning clinics. In the second, semi-structured telephone interviews were completed with a random sample of 76 GPs from three English health authorities. Interviews were recorded, transcribed and thematic analysis was conducted using the constant comparative method. EC was rarely described, by users or GPs, as an

acceptable contraceptive option. Consultations for emergency contraception were viewed by GPs as an important opportunity to discuss the woman's future contraceptive needs. Repeated use of EC was not encouraged and a discussion of contraceptive needs could range from a mild enquiry to quite forceful messages contrasting EC to 'regular' and 'proper' methods. The medical literature suggests that EC is underused because of a lack of awareness. Commentators have recommended educating health professionals and women about EC and increasing availability through de-regulation. The data presented in this paper show that British GPs are not enthusiastic about the de-regulation of EC, but the reasons are complex and related to concerns about planned contraception and sexual behaviour. It is suggested that it may be because EC is used after sex that it seems to occupy an uncomfortable place within the contraceptive repertoire.

(55)

The politics of prevention. Issues in emergency contraception.

Adv Nurse Pract 1999 Nov;7(11):60-2

Peters S

(56)

Women's knowledge and attitudes about emergency contraception: a survey in a Melbourne women's health clinic.

Aust N Z J Obstet Gynaecol 1999 Nov;39(4):460-4

McDonald G, Amir L

Murdoch Institute, Australia.

ABSTRACT:

The aim of the study was to determine the level of awareness of emergency contraception in women seeking pregnancy counselling and to investigate their attitudes towards emergency contraception. All women presenting for pregnancy counselling at a Melbourne women's health clinic in October 1997 were invited to complete a questionnaire detailing their contraceptive practices. One hundred and sixty-six questionnaires were distributed and 153 were completed (92% response rate). The majority of this sample population had heard of some form of emergency contraception and knew where to access it. However only 26% knew that emergency contraception should be taken within 72 hours of unprotected intercourse. Although 80% of the sample had heard of emergency contraception (or the morning after pill) only 9% used it in an attempt to prevent this pregnancy. The majority of the women surveyed support the increased availability of emergency contraception by rescheduling it to a non-prescription item and re-packaging as a single treatment.

(57)

Update on levonorgestrel for emergency contraception.

J Fam Pract 1999 Dec;48(12):1002

Strayer SM, Couchenour RL

LETTER

(58)

Pushing the frontiers of science: reflections on an Institute of Medicine study.

Int J Gynaecol Obstet 1999 Dec;67 Suppl 2:S93-9

Rosenfield A

Joseph L. Mailman School of Public Health, Columbia University, New York, NY, USA.

Abstract:

A women-centered contraceptive research agenda was the focus of a 1996 Institute of Medicine Committee report. Priority was given to research on methods that act as a chemical or physical barrier to conception and to STDs including HIV; to menses inducers and once-per-month methods; and to male contraceptive methods. Much progress has been made since the 1996 report. This paper summarizes this progress. New research has been developed in the three priority areas, collaboration activities have been developed between the public and private sectors, and emergency contraception has been introduced to the US. Controversies are discussed in relation to immunocontraception, stem cell research and fetal tissue research. Finally there is a brief report on the lessons to be learned from the experience of the introduction of the implant, Norplant, in the US.

(59)

Collaborative research and development on mifepristone in China to reduce unwanted pregnancies and recourse to abortion.

Int J Gynaecol Obstet 1999 Dec;67 Suppl 2:S69-76

(Duncan GW)seattll@thewcc.com

Abstract:

A program proposed and executed by The Concept Foundation and funded by the Rockefeller Foundation demonstrates the feasibility of using private/public-sector collaboration for making mifepristone widely available. The application of mifepristone to emergency, luteal phase and menstrual induction contraception is being assessed in clinical research programs conducted in accordance with international standards for good clinical research. Opportunities for introduction of mifepristone in developing countries are being pursued using mifepristone produced in China in accordance with international standards of good manufacturing practice.

(60)

Women's knowledge of and attitudes towards emergency contraception in Hong Kong: questionnaire survey.

Hong Kong Med J 1999 Dec;5(4):349-352

Lee SW, Wai MF, Lai LY, Ho PC

Department of Obstetrics and Gynaecology, The University of Hong Kong, Queen Mary Hospital, Pokfulam, Hong Kong.

OBJECTIVE: To study the level of knowledge of and attitude towards emergency contraception in a group of women requesting the termination of pregnancy. DESIGN: Structured questionnaire survey. SETTING: Family Planning Association and university teaching hospital, Hong Kong. PARTICIPANTS: Two hundred women who requested the termination of an unplanned pregnancy between May 1997 and March 1998. MAIN OUTCOME MEASURES: Demographic data, basic knowledge of contraception, reasons for

terminating the pregnancy, and knowledge and usage of emergency contraception. RESULTS: A substantial proportion (33.0%) of women was ignorant of the existence of emergency contraception. Only 10.0% of women had used emergency contraception before and only 2.5% had used it in an attempt to prevent this pregnancy. Of the 134 women who knew about emergency contraception, the main reason (41.8%) for not using it was risk-taking behaviour. More nulliparous women (88.5% versus 57.6%; $P<0.001$) and women younger than 20 years (84.0% versus 61.3%; $P<0.01$) had heard of emergency contraception. Women who were educated beyond secondary school level (71.0% versus 37.5%; $P<0.01$) and unmarried women compared with married, cohabiting, or divorced women (87.1% versus 49.5%; $P<0.001$) were also more likely to have heard of emergency contraception. Women younger than 20 years were more likely to have used this form of birth control in the past (18.0% versus 7.3%; $P<0.05$). CONCLUSION: There is a need to improve women's education about emergency contraception in Hong Kong.

(61)

A new model for collaboration--making emergency contraceptives available in developing countries.

Int J Gynaecol Obstet 1999 Dec;67 Suppl 2:S59-65; discussion S67

Senanayake P

(International Planned Parenthood Federation, Regent's College, Regent's Park, London, UK.)

Abstract:

Private/public-sector collaboration in contraceptive research and development offers a fresh opportunity to consider a holistic approach to making emergency contraception (EC) available in developing countries. Emergency contraception has been available since the 1970s but has remained under-utilized. Emergency contraception may be used by women who want to prevent a pregnancy and therefore has a specific use, in a specific situation. This paper highlights the distinct and reciprocal advantages of a collaborative approach between the Consortium for Emergency Contraception (the public sector) and a pharmaceutical company (the private sector), to the introduction of EC in developing countries. The importance of cultivating a public/private-sector collaborative approach, which serves the interests of both parties concerned, in order to foster progress in this important initiative, is highlighted.

(62)

Use and knowledge of hormonal emergency contraception.

Adv Contracept 1999;15(2):85-94

Virjo I, Kirkkola AL, Isokoski M, Mattila K

University of Tampere, Medical School, Department of General Practice, Finland.

Abstract:

Hormonal emergency contraception (EC) is an acceptable means of postcoital prevention of pregnancy, but potential users should have information and education about it before they need it. The aim of this study was to establish how many women and how many men's partners have used hormonal EC and how well the respondents know the correct time to take EC pills. Random samples (393 women and 395 men) were drawn from the Finnish population register. Response rates were 56% for women and 45% for men. Of all responding women and men, 12% had themselves or together with their partners used EC. The proportion of EC users was highest in the younger age group among both women and men. It was greater among single and cohabiting women than among married women. Only a minority of respondents knew that EC pills could be

taken up to 72 h after unprotected intercourse. Women who had used EC were most knowledgeable, as were also the younger age groups among both women and men. Awareness of the availability of EC and of its correct use should be further promoted to avoid unwanted pregnancies.

(62b)

On behalf of the Task Force on Postovulatory Methods of Fertility Regulation. Timing of emergency contraception with levonorgestrel or the Yuzpe regimen

Lancet 1999, 353:9154.

Piaggio G, von Hertzen H, Grimes DA y cols.

(63)

Quality of information on emergency contraception on the Internet.

Br J Fam Plann 2000 Jan;26(1):39-43

Latthe M, Latthe PM, Charlton R

OBJECTIVE: To evaluate the quality of patient information about emergency contraception on the Internet. **DESIGN:** We performed an on-line search of the Internet and found relevant World Wide Web sites by combining the key phrases 'emergency contraception' and 'patient information' in two Web subject guides and two search engines. We defined quality as the extent to which the characteristics of a Web site satisfied its stated and implied objectives. Our assessment focused on credibility and content of each Web site. Credibility was assessed by source, currency and editorial review process and content of Web site was assessed by hierarchy and accuracy of evidence. **RESULTS:** Our search revealed 32 relevant Web sites, none of which complied with all of the criteria for quality of credibility and content. Twenty-eight Web sites displayed the source clearly, 17 Web sites showed currency, and none of the Web sites had an editorial review process. Only six of the 32 sites mentioned hierarchy of evidence. None of the Web sites depicted all the criteria for accuracy of contents. **CONCLUSION:** None of the Web sites provided complete information to patients about emergency contraception according to the quality criteria used in this study. As previous studies have shown, people need to be wary about the quality of information on the Internet.

(64)

Provider knowledge about emergency contraception in Ghana.

J Biosoc Sci 2000 Jan;32(1):99-106

Steiner MJ, Raymond E, Attafuah JD, Hays M

Family Health International, Research Triangle Park, NC 27709, USA.

Abstract:

In 1996, the Ministry of Health in Ghana included emergency contraception (EC) in its newly issued National Reproductive Health Service Policy and Standards. A short survey was conducted in the summer of 1997 to evaluate health providers' knowledge of EC. Of the 325 providers interviewed, about one-third (34%) had heard of EC. No provider had sufficient knowledge to prescribe EC correctly. A well-coordinated training programme for providers will have to precede successful introduction of EC in Ghana. Moreover, a dedicated product may be critical for the successful introduction of EC in a country like Ghana, where provider knowledge is low.

(65)

Interventions for emergency contraception.

Cochrane Database Syst Rev 2000;(2):CD001324

Cheng L, Gulmezoglu AM, Ezcurra E, Van Look PF

(UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Reproductive Health and Research, World Health Organization, 1211-Geneva 27, SWITZERLAND). gulmezoglu@who.ch

OBJECTIVES: To determine which emergency contraceptive method following unprotected intercourse is the most effective, safe and convenient for use in preventing pregnancy. **SEARCH STRATEGY:** The search strategy included electronic searches of the Cochrane Controlled Trials Register, Popline, Chinese biomedical databases and HRP emergency contraception database. In addition, references of retrieved papers were searched and researchers in the field and two pharmaceutical companies were contacted. **SELECTION CRITERIA:** Randomized or quasi-randomized studies including women attending services for emergency contraception following a single act of unprotected intercourse were eligible. **DATA COLLECTION AND ANALYSIS:** Data on outcomes and trial characteristics were extracted in duplicate by two reviewers. Results were expressed as relative risk using a fixed-effects model with 95 % confidence interval. **MAIN RESULTS:** Fifteen trials were included in the review. The majority (8/15) of the trials were conducted in China. Most comparisons between different interventions included one or two trials although some trials were appropriately sized with power calculations. Levonorgestrel appears to be more effective than Yuzpe regimen (2 trials, RR: 0.51, 95 % CI: 0.31-0.84) and causes less side-effects (RR: 0.80, 95 % CI: 0.76 to 0.84). Levonorgestrel was less effective than locally manufactured mifepristone in a single, large Chinese study (RR: 2.17, 95 % CI: 1.00 to 4.77). Effectiveness of different doses of mifepristone seem to be similar but the frequency of delay in onset of the subsequent menstrual period increases with increased dose. **REVIEWER'S CONCLUSIONS:** Levonorgestrel and mifepristone seem to offer the highest efficacy with an acceptable side-effect profile. One disadvantage of mifepristone is that it causes delays in onset of subsequent menses which may induce anxiety. However, this seems to be dose-related and low doses of mifepristone minimise this side-effect without compromising effectiveness. Future studies should compare the effectiveness of mifepristone with levonorgestrel.

REVIEW

(66)

Emergency contraception.

Adv Pediatr 2000;47:309-34

Gold MA

(University of Pittsburgh School of Medicine, Pa., USA.)

Abstract:

High rates of adolescent pregnancy remain a challenge for health care providers. For most sexually active adolescents, pregnancy is unintended. Emergency contraception, also called the "morning-after-pill" or postcoital contraception, is a way to prevent pregnancy after unprotected intercourse. In the United States, three forms of emergency contraception currently are available: high-dose combination estrogen and progestin pills, high-dose progestin-only pills, and postcoital insertion of a copper intrauterine device. The postcoital intrauterine device is used infrequently. When emergency contraceptive pills (ECPs) are taken

within 72 hours of unprotected intercourse, they reduce the risk of pregnancy by at least 75%. However, they are most effective if taken within 24 hours of coitus. Eleven brands of pills currently are marketed in the United States that conform to the regimens approved by the Food and Drug Administration (FDA) for this indication. Recently, two prepackaged ECPs were approved by the FDA. The only medical contraindication to prescribing ECPs is pregnancy. The most common side effects are nausea and vomiting, followed by menstrual disturbances, breast tenderness, abdominal cramping, dizziness, headache, and mood changes. Because vomiting can compromise the efficacy of ECPs, routine pretreatment with an antiemetic is recommended. Primary care providers can reduce unintended adolescent pregnancy by routinely counseling adolescents at all office visits about the existence of emergency contraception and by prescribing it in advance and over the telephone.

(67)

Knowledge and use of emergency postcoital contraception by female students at a high school in Nova Scotia.

Can J Public Health 2000 Jan-Feb;91(1):29-32

Langille DB, Delaney ME

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PURPOSE: This study was performed in the context of a sexual health promotion project in a Nova Scotia community. Community members wanted information about adolescent females' knowledge and use of emergency contraception (EC). The study was done to meet this need. **METHODS:** Female high school students aged 14 to 19 were administered a self-completion survey asking about their knowledge of EC, the time frame for its use, its effectiveness, their personal use of EC, unsuccessful attempts to obtain EC, and sources of knowledge of EC. **RESULTS:** Eighty-five percent of 411 female students participated. Eighty percent knew about EC, though few (8%) knew the time frame for EC use. Most (42%) heard of EC at school. Eighteen percent used no contraception at last intercourse. Only 2% ever had used EC. **CONCLUSIONS:** Adolescent women know about EC but use it infrequently, even though they frequently lack contraception. These findings raise questions about alternative methods for providing EC to young women.

(68)

Access to emergency contraception.

Obstet Gynecol 2000 Feb;95(2):267-70

Trussell J, Duran V, Shochet T, Moore K

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OBJECTIVE: To evaluate access to emergency contraception among women seeking help from clinicians who registered to be listed on the Emergency Contraception Hotline (1-888-NOT-2-LATE, ie, 1-888-668-2528) and the Emergency Contraception Website (not-2-late.com). **METHODS:** Two college-educated investigators posing as women who had a condom break the previous night called 200 providers to seek help. **RESULTS:** Only 76% of attempts resulted in an appointment or telephone prescription from a hotline provider within 72 hours, 14% were failures, and 11% resulted in referrals to other providers not listed on the hotline or website. **CONCLUSION:** Even under ideal conditions, access to emergency contraception is currently constrained. Although emergency contraception could reduce significantly the incidence of unintended pregnancy and the consequent need for abortion, its potential will not be realized unless women have better access to clinicians who can prescribe emergency contraceptive pills.

(69)

Meclizine for prevention of nausea associated with use of emergency contraceptive pills: a randomized trial.

Obstet Gynecol 2000 Feb;95(2):271-7

Raymond EG, Creinin MD, Barnhart KT, Lovvorn AE, Rountree RW, Trussell J

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OBJECTIVE: We conducted a randomized trial to determine whether pretreatment with meclizine reduces the incidence of nausea and vomiting associated with the Yuzpe regimen of emergency contraception. **METHODS:** We randomly assigned 343 women aged 18-45 years who were not at risk for pregnancy to pretreatment with 50 mg of meclizine, placebo, or no drug 1 hour before the first of two doses of emergency contraceptive pills. We asked participants to complete three questionnaires over the following 48 hours. **RESULTS:** The incidence of nausea was 47% in the group pretreated with meclizine and 64% in the other two groups (relative risk adjusted for center 0.7, 95% confidence intervals 0.6, 0.9 for comparisons of meclizine with both placebo and no drug). The severity of nausea and the incidence of vomiting were also significantly lower in the meclizine pretreatment group than in the other two groups. Drowsiness was reported by about twice as many women in the meclizine pretreatment group (31%) than in the other two groups (13% in the placebo group, 16% in the no-pretreatment group; $P < .01$ for both comparisons). **CONCLUSION:** Meclizine is effective for preventing nausea and vomiting associated with the Yuzpe regimen of emergency contraceptive pills. Women using this drug should be cautioned to anticipate drowsiness.

CLINICAL TRIAL

(70)

Emergency contraception: a review of the programmatic and social science literature.

Contraception 2000 Mar;61(3):145-86

Ellertson C, Shochet T, Blanchard K, Trussell J

(Population Council, DF, Col. Villa Coyoacan, Mexico.)

Abstract:

Many biomedical aspects of emergency contraception have been investigated and documented for >30 years now. A large number of social science questions, however, remain to be answered. In this article, we review the rapidly growing but geographically lopsided literature on this topic. Using computer database searches supplemented by reference reviews and professional correspondence with those active in the field, we gathered literature on the social science and service delivery aspects of emergency contraception published in English up through December 1998, as well as a few unpublished papers from the same time and slightly later, representing regions where published material is practically nonexistent. Methodologically acceptable papers are summarized in our tables and text, and form the basis for suggested improvements in existing emergency contraceptive services. The review also offers ideas for designing new emergency contraception services where they do not yet exist. We conclude by proposing an agenda for further social science research in this area.

REVIEW

(71)

Emergency contraception: a simple, safe, effective and economical method for preventing undesired pregnancy. [Article in Spanish]

Rev Invest Clin 2000 Mar-Apr;52(2):168-76

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Abstract:

In the following article, the most recent knowledge on emergency contraception (EC) is reviewed. EC is defined as those contraceptive methods that may be used to prevent an unwanted pregnancy up to 3 days after unprotected intercourse, contraceptive failure or rape. In case of non-hormonal methods (IUD), the time window for pregnancy prevention goes up to 5 days after intercourse. The different regimens now available, hormonal and non-hormonal methods, indications, contraceptive effectiveness, side effects and safety profile, possible mechanisms of action and counseling strategies will be reviewed. The potential benefits on reproductive health of wide-spread knowledge and easy, non-restrictive access to this methodology are emphasized. An extensive list of recent references is enclosed.

REVIEW

(72)

The associations among pediatricians' knowledge, attitudes, and practices regarding emergency contraception.

Pediatrics 2000 Apr;105(4 Pt 2):954-6

Sills MR, Chamberlain JM, Teach SJ

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OBJECTIVES: To quantify practitioner administration of the emergency contraceptive pill (ECP) among adolescent patients, and to determine if such administration is associated with physician knowledge and attitudes regarding efficacy, side effects, and appropriate use. **DESIGN:** Survey of pediatricians. **SETTING:** The survey address list was generated from a database of active Fellows of the American Academy of Pediatrics in the District of Columbia metropolitan area. **MAIN OUTCOMES MEASURES:** Prescription of the ECP in the previous 12 months, or counseling of an adolescent patient about the ECP. **RESULTS:** Of the 236 questionnaires distributed, 143 (61%) were returned and 121 (51%) were usable. Twenty-four pediatricians (20%) reported prescribing the ECP, and 29 (24%) had counseled adolescent patients about the ECP. Of the practice-related variables surveyed, both the number of adolescents seen per week and the practice setting were significantly associated with these outcomes. Of the knowledge-related variables surveyed, knowledge of the timing and the Food and Drug Administration-labeled status of the ECP were significantly associated with outcomes. None of the attitude-related variables surveyed were associated with outcomes. **CONCLUSIONS:** This study demonstrates that knowledge deficits, not attitude-related variables, are significantly associated with the low level of ECP administration and counseling among District of Columbia pediatricians. Because knowledge deficits are amenable to educational interventions, our data suggest that informing pediatricians about the ECP may increase its administration among their adolescent patients. emergency contraceptive pill, pediatricians, adolescents.

(73)

Emergency contraception with levonorgestrel: one hormone better than two.

Br J Fam Plann 2000 Apr;26(2):67-9

O'Brien PA

EDITORIAL

(74)

Provision of emergency contraceptive pills to spermicide users in Ghana.

Contraception 2000 Apr;61(4):287-93

Lovvorn A, Nerquaye-Tetteh J, Glover EK, Amankwah-Poku A, Hays M, Raymond E

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Abstract:

This study evaluated the effect of two approaches to provision of emergency contraceptive pills (ECPs) on ECP use and unprotected intercourse among women relying on spermicides for contraception. The study enrolled 211 women at 4 family planning clinics in Ghana. At two clinics, participants were advised to return to the clinic within 3 days after unprotected intercourse to obtain ECPs. At the other two clinics, participants were given ECPs to take home for use if unprotected intercourse occurred. All participants were asked to maintain daily diaries for 8 weeks to record information on sexual activity, spermicide use, and ECP use. Women at all clinics used ECPs after at least 78% of unprotected coital acts. ECPs were used more promptly by women who had the pills at home. At three of the clinics, at most 1.3% of the coital acts were unprotected; at the fourth, 6.7% were unprotected. Our data did not suggest that the availability of ECPs increased the frequency of unprotected intercourse.

(75)

What do family planning clients and university students in Nairobi, Kenya, know and think about emergency contraception?

Afr J Reprod Health 2000 Apr;4(1):77-87

Muia E, Ellertson C, Clark S, Lukhando M, Elul B, Olenja J, Westley E

(Population Council, Nairobi.)

Abstract:

Currently, emergency contraception is seldom used in Kenya. As part of a larger study designed to provide insight into the possible roles for the method in Kenya, we assessed the knowledge of and attitudes towards emergency contraception in two groups of potential users, and we focus on these data specifically in this paper. We interviewed clustered samples of clients at ten family planning clinics in Nairobi (n = 282) and conducted four focus group discussions with students at two universities in Kenya (n = 42). Results show that despite relatively low levels of awareness and widespread misinformation, when the method was explained, both clients and students expressed considerable interest, but also expressed some health and other concerns.

(76)

Perception and practice of emergency contraception by post-secondary school students in southwest Nigeria.

Afr J Reprod Health 2000 Apr;4(1):56-65

Arowojolu AO, Adekunle AO

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College Hospital, Ibadan, Nigeria.

Abstract:

A survey of 1500 students in post-secondary institutions in southwest Nigeria showed that the concept of emergency contraception (EC) was well known. Respectively, 32.4%, 20.4% and 19.8% knew that combined pills, progesterone only pills and intrauterine contraceptive device (IUCD) were usable for EC, while 56.7% mentioned the use of traditional methods. Only 11.8% had ever used either pills or IUCD and 10.7% had used a traditional method. Few students (11.5% and 2.3% respectively) knew the correct timing of EC pills and IUCD. The respondents reported varying circumstances under which EC was indicated but the majority cited condom breakage and sexual assault. The popular media represent the commonest source of information while hospitals/clinics were the commonest sources of procurement. About 37% of the respondents planned to use EC in future while 58% would not and 4.7% were uncertain. Reasons for these responses were explored.

(77)

Emergency contraception. [Article in French]

Ann Endocrinol (Paris) 2000 May;61(2):143-4

Aubenny E

Presidente de l'ADMCU/AFC, Centre d'Orthogenie, Hopital Broussais, Paris.

(78)

OTC access to emergency contraception-"the French model"-what's your vote?

J Pediatr Adolesc Gynecol 2000 May;13(2):51-2

Sanfilippo JS

EDITORIAL

(79)

Use of 0.75 mg Levonorgestrel for postcoital contraception in Thailand.

J Clin Pharm Ther 2000 Jun;25(3):185-90

Lerkiatbundit S, Reanmongkol W.

(Department of Pharmacy Administration, Faculty of Pharmaceutical Sciences, Prince of Songkla University, Hadyai Songkla Thailand 90112.) lsanguan@makok.pharmacy.psu.ac.th

OBJECTIVE: This study identified the pattern of Levonorgestrel (LNG) use and self-reported side-effects among Thai women in Songkla. **METHOD:** The eligible subjects were 100 Thai women who had used 0.75 mg LNG at least once in the past 12 months. The participants completed a questionnaire at the survey sites, which were seven pharmacies and five shopping malls. **RESULTS:** Eight percent of LNG users had never used any contraceptive methods other than day count and withdrawal. Thirty-nine percent took more than four tablets of LNG per month, which was the limit instructed in the label. Only 3% used LNG for emergency situations such as having unprotected intercourse or burst condom. At least 22% of subjects took LNG according to instructions which were last revised 2 years earlier. The study also revealed poor knowledge among the users on side-effects and limit of drug use. Compared to the previous studies, this study found a higher incidence of side-effects. Forty-four percent of subjects experienced cycle disturbances and 32% nausea, respectively. **CONCLUSION:** The Thai FDA should seriously consider requiring manufacturers to revise labels of LNG to be consistent with those recommended by WHO.

(80)

Emergency contraception: methods and efficacy.

Curr Opin Obstet Gynecol 2000 Jun;12(3):175-9

Ho PC.

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Abstract:

A number of effective and safe methods for emergency contraception are now available. High doses of oestrogens, although effective, are seldom used nowadays because of the high incidence of nausea and vomiting, and the need for administration for 5 days. The Yuzpe regimen, consisting of administration of two doses of combined oral contraceptive pills with a 12-h interval, can prevent more than 74% of expected pregnancies, but the incidence of side effects, mainly gastrointestinal side effects, is high. Levonorgestrel and mifepristone are more effective than the Yuzpe regimen and have a lower incidence of side effects. They can prevent about 85% of pregnancies. The efficacy of both the Yuzpe regimen and levonorgestrel decreased with increase in the intercourse-treatment interval. The dose of mifepristone can be reduced to 10 mg without loss of efficacy. Both levonorgestrel or mifepristone are not yet widely available, and the Yuzpe regimen remains the only hormonal method in many countries. The postcoital insertion of an intrauterine contraceptive device is also a highly effective method, which can prevent over 90% of pregnancies.

Review, tutorial

(81)

Knowledge and willingness to use emergency contraception among low-income post-partum women.

Contraception 2000 Jun;61(6):351-7

Jackson R, Bimla Schwarz E, Freedman L, Darney P.

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rjack@itsa.ucsf.edu

Abstract:

We performed a multivariate analysis to determine factors associated with knowledge and willingness to use emergency contraception in a consecutive sample of 371 post-partum women from an inner-city public hospital. Women were queried about previous contraceptive use, pregnancy history including abortions and unplanned pregnancies, and demographic characteristics. Outcomes included knowledge of emergency contraception and willingness to use it. Questionnaires were conducted in person, in English or Spanish. Of 371 women, 3% had used emergency contraception, 36% had heard of it, and 7% knew the correct timing for use. Two-thirds of the population indicated a willingness to use emergency contraception in the future. Factors positively associated with knowledge included being a teenager or more than 30 years old, prior use of condoms, and history of an elective abortion. Being multiparous, monolingual Spanish-speaking, or Asian were negatively associated with knowledge. Willingness to use emergency contraception was positively associated with being multiparous and negatively associated with a higher income, moral or religious objections to the use of emergency contraception, a belief that it is unsafe or a perception that it is an abortifacient. Knowledge about emergency contraception, especially correct timing, remains low. Multiparous women should receive increased education given their lack of knowledge but willingness to use emergency contraception. In order to increase the acceptability of emergency contraception, educational efforts must include accurate information about its mechanism of use and safety.

(82)

Emergency contraception.

Arch Fam Med 2000 Jul;9(7):642-6

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Abstract:

Emergency contraception is used after unprotected intercourse or a contraceptive accident to prevent unwanted pregnancy. It is thought to work by stopping or delaying ovulation or preventing implantation if fertilization has already taken place. Hormonal methods, mifepristone, and intrauterine device insertion are among the methods used worldwide. Combination estrogen-progestin birth control pills are the most commonly used form of emergency contraception in the United States. According to the Yuzpe method, combination pills are taken within 72 hours after intercourse, followed by a second identical dose 12 hours later. With this method, the number of unintended pregnancies is reduced by about 75%. Nausea and vomiting are the most troublesome adverse effects, but these can be controlled with antiemetic medication taken prior to the first dose. The Food and Drug Administration, Washington, DC, has approved an emergency contraception kit consisting of 4 combination pills, a urine pregnancy test, and a patient information book. Post recently, the Food and Drug Administration has approved a progestin-only formulation, which has fewer adverse effects and equal or improved efficacy compared with the combination formula. An intrauterine device can be inserted up to 5 days after unprotected intercourse and is a cost-effective option if it is used as ongoing contraceptive protection. The most readily available form of emergency contraception consists of 2 doses of estrogen-progestin combination birth control pills or 2 levonorgestrel pills taken 12 hours apart. Emergency contraception should not be considered as an alternative to ongoing contraceptive methods, but can prevent unwanted pregnancy.

Review, tutorial

(83)

Emergency contraception: advance provision in a young, high-risk clinic population.

Obstet Gynecol 2000 Jul;96(1):1-7

Raine T, Harper C, Leon K, Darney P.

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OBJECTIVE: To assess whether advance provision of emergency contraception increases its use and whether it has secondary effects on regular contraceptive use. **METHODS:** We conducted a controlled trial of female clients, aged 16-24 years, who attended a publicly funded family planning clinic. Women were systematically assigned to receive an advance provision of emergency contraception and education (treatment) or education only (control). Among 263 participants enrolled (133 treatment, 130 control), follow-up was completed in 213 (111 treatment, 102 control). The main outcome measures were emergency contraception knowledge and use, frequency of unprotected sex, and pattern of contraceptive use in the past 4 months. **RESULTS:** Participants were aware of emergency contraception at follow-up, but the treatment group was three times as likely to use it ($P = .006$). Although the treatment group did not report higher frequencies of unprotected sex than the control group, women in the treatment group (28%) were more likely than those in the control group (17%) to report using less effective contraception at follow-up compared with enrollment ($P = .05$). The proportion of women in both groups who reported consistent pill use increased from enrollment to follow-up (34% versus 45%); however, the control group (58%) was more likely than the treatment group (32%) to report consistent pill use at follow-up ($P = .03$). **CONCLUSION:** Use of emergency contraception was increased by providing it in advance, but not by education alone. Changes to less effective contraceptive methods and patterns of pill use were potentially negative effects that need to be explored in relation to observed benefits.

(84)

Differences between users and non-users of emergency contraception after a recognized unprotected intercourse.

Contraception 2000 Jul;62(1):1-3

Sorensen MB, Pedersen BL, Nymberg LE.

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Abstract:

Knowledge of emergency contraception is crucial but might not transform into use. Factors influencing decision-making related to use of emergency contraception after an unprotected intercourse and the characteristics of users of emergency contraception (EC) were assessed. In an abortion clinic setting, 217 women referred for termination of pregnancy were asked to fill in a questionnaire. Of the 217 women, 139 (64%) were aware of pregnancy risk but only 9 (4%) had used EC after the unprotected intercourse. 42% were estimated to have sufficient knowledge to use hormonal emergency contraception. In a larger background population, a calculated 29% used EC after a recognized unprotected intercourse. EC users were older, better educated, more often in stable relationships, had experienced more abortions, and gestation age was less. However, younger women were in general better informed of EC. Knowledge of EC does not necessarily transform into action. Neglect of risk after an unprotected intercourse is frequent in younger well-informed women and information has to be better targeted.

(85)

Repeated use of hormonal emergency contraception by younger women in the UK.

Br J Fam Plann 2000 Jul;26(3):138-43

Rowlands S, Devalia H, Lawrenson R, Logie J, Ineichen B.

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Abstract:

A cohort of women aged 14-29 in 1993 was identified from the General Practice Research Database and followed up for a period of 4 years. Patient files were searched for evidence of use of emergency contraception and regular contraception. Of the 95 007 women, 15 105 (16%) had received emergency contraception during the study period (an average of 5% per annum). There was a small year on year increase in uptake of emergency contraception between 1994 and 1997. Only 4% of emergency contraception users received emergency contraception more than twice in any year. More than 70% of those who had no previous record of use of regular contraception had used regular contraception within 1 year of using emergency contraception. Teenagers were more likely than other age groups to use emergency contraception, to be repeat users of emergency contraception and to fail to start regular contraception after first use of emergency contraception until later in the study period. These results disprove the notion of widespread repeated use of emergency contraception. They show that provision of an emergency contraception service does not result in failure to initiate regular contraception or abandonment of regular contraception; rather they show many women using regular contraception for the first time after use of emergency contraception.

(86)

Emergency contraception in clinical practice: global perspectives.

Int J Gynaecol Obstet 2000 Jul;70(1):49-58

Bartfai G.

(Department of Obstetrics and Gynecology, Albert Szent-Gyorgyi Medical University, Szeged, Hungary.)

Abstract:

Access to reliable contraception is often unavailable. Unsafe abortion yearly causes death for thousands and disabling illness for millions worldwide. Insufficient information, negligence, inappropriate contraception, poverty and poor education contribute to these serious sequelae of unintended pregnancy. Identification of those at risk, the provision of appropriate information and access to emergency co ntraception (EC), and male involvement are emphasized. Improved knowledge, better attitudes, enhanced practice of EC, and determined providers might meet the requirements of the next century.

(87)

Alleged sexual assault. The role of the emergency department gynecologist

Minerva Ginecol 2000 Jul-Aug;52(7-8):313-20

Lukic A, Sassi MT, Vecchiotti C, Vetrano G.

II Istituto di Clinica Ostetrica e Ginecologica, Universita degli Studi di Roma La Sapienza, Roma.

Abstract:

The objective of this paper is to better understand the role of the Emergency department gynecologist in cases of alleged sexual assault. The gynecologist should know that he is a justice collaborator and, as public officer, he has to report to authorities every indictable offense. He should also know that patient's informed consent is

required during each step of medical investigation. The doctor should indeed know when, how and where to find and collect evidence of crime and perform, in conformity with the victim's statement, specimens of biologic samples, a pregnancy test and a prophylaxis of sexually transmitted diseases. The gynecologist should evaluate psychological and general state of the patient, take the tailored medical history including the modalities of violent act, perform a physical examination, a genital and rectal examination with accurate description of the lesions and collect evidence of rape. The role of the gynecologist is to document all injuries in order to afterwards establish the conformity with patient's history. He should treat acute physical injuries, offer the counseling for the prevention of sexually transmitted diseases, for the pregnancy prophylaxis and emergency contraception and for psychosocial consequences, report to authorities as required by law and, at last, arrange for follow-up medical care and counseling. Personal experience highlights the necessity of a standard protocol to be used in all Emergency departments. This would allow and facilitate an uniform medical approach to the sexual assault victim as well as an accurate and correct collection of data for legal requirements.

(88)

Emergency contraception knowledge and prescribing practices: a comparison of primary care residents at a teaching hospital.

J. Pediatr Adolesc Gynecol 2000 Aug;13(3):125-8

Veloudis GM Jr, Murray SC.

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STUDY OBJECTIVE: To determine knowledge, opinion, and experience concerning emergency postcoital contraception in primary care physicians who are in training. **DESIGN:** Cross-sectional survey using a questionnaire survey distributed to primary care specialty housestaff. **SETTING:** Questionnaire surveys were distributed to all active primary care housestaff in training and Obstetrics and Gynecology attendings at the University of Kentucky. **PARTICIPANTS:** The study surveyed all primary care specialty housestaff. Specialties included family practice (FP), internal medicine (IM), pediatrics (PD), and obstetrics and gynecology (OG). The attending faculty in Obstetrics and Gynecology (OGA) were also surveyed as a comparison group. **MAIN OUTCOME**

MEASURES: Study variables were compared between specialty of training, year of training, and abortion opinion. ANOVA or Student's t tests were used, with statistical significance defined as $P < .05$. Each questionnaire was scored 0 to 9 based on knowledge and utilization questions. Overall response rate was 48%, 90 out of 189 surveyed. Response rates per specialty are as follows: FP = 51%, IM = 37%, PD = 48%, OG = 65%, and OGA = 69%. **RESULTS:** The average score on the survey was significantly different based on specialty of training (P value $< .0001$). Scores were not significantly different based on year of training. However, the average attending OG's score was significantly higher than for all the housestaff (P value $< .0001$). **CONCLUSION:** Knowledge and utilization of postcoital contraception is dependent on specialty. Unfortunately, this knowledge does not appear to increase with year of training, suggesting that there is a lack of education during the years of training.

(89)

Emergency contraception.

CMAJ 2000 Aug 8;163(3):261

Cole M.

Comment on:

CMAJ. 2000 May 30;162(11):1554

(90)

Consultation patterns and provision of contraception in general practice before teenage pregnancy: case-control study.

BMJ 2000 Aug 19-26;321(7259):486-9

Churchill D, Allen J, Pringle M, Hippisley-Cox J, Ebdon D, Macpherson M, Bradley S.

(Division of General Practice, University of Nottingham Medical School, Queen's Medical Centre, Nottingham NG7 2UH, UK.) dick.churchill@nottingham.ac.uk

OBJECTIVES: To determine patterns of consultation in general practice and provision of contraception before teenage pregnancy. **DESIGN:** Case-control study, with retrospective analysis of case notes. Setting: 14 general practices in Trent region. **SUBJECTS:** 240 registered patients (cases) with a recorded conception before the age of 20. Three controls per case were matched by age and practice. **MAIN OUTCOME MEASURES:** Consultations in general practice and provision of contraception in the 12 months before conception and recorded provision of contraception at any time before conception. **RESULTS:** Overall, 223 cases (93%) had consulted a health professional at least once in the year before conception, 171 (71%) had discussed contraception in this time, and 121 (50%) had been prescribed oral contraception. Cases were more likely to have consulted in the year before conception than controls (odds ratio 2.70, 95% confidence interval 1.56 to 4.66). Most of the difference was owing to consultation for contraception. Overall, 53 cases (22%) resulted in a termination of pregnancy. Cases whose pregnancy ended in a termination were more likely to have received emergency contraception than either their controls (3.21, 1.32 to 7.79) or cases resulting in other outcomes (3.01, 1.06 to 8.51). **CONCLUSIONS:** Most teenagers who became pregnant attended general practice in the year before pregnancy, and many had sought contraceptive advice. The reluctance of teenagers to attend general practice for contraception may be less than previously supposed. The association between provision of emergency contraception and pregnancy ending in termination emphasises the need for continuing follow up of teenagers consulting for this form of contraception.

(91)

Contraception prior to counselling for termination of pregnancy.

Eur J Contracept Reprod Health Care 2000 Sep;5(3):192-7

Jaffer K, Newton JR.

Department of Community Gynaecology, Birmingham Women's Hospital, Edgbaston, UK.

OBJECTIVE: This study investigates the methods of contraception used by women attending for pregnancy counselling at the time of an unintended pregnancy. **METHOD:** Women attending three pregnancy counselling clinics in Birmingham were asked to fill in a questionnaire which was designed to obtain demographic data and history of women's methods of contraception, prior to attending for termination of pregnancy. **RESULTS:** The contraceptive methods used most widely by women presenting for termination of pregnancy were the condom (n = 188; 43%) and the oral contraceptive pill (n = 96; 22%). A proportion of women did not use any contraception (n = 117; 27%). Women who had undergone a previous termination of pregnancy (32%) [corrected] had similar contraceptive patterns to those with no history of termination of pregnancy. Women aged 19 and under were less likely to be using contraception (non-users 30/90; 33%) compared with women aged 20 and over (non-users 82/324; 25%), but this difference was not statistically significant. Forty per cent (n = 31) of Afro-Caribbeans did not use any contraception; this was statistically significant when compared with the percentage of Caucasians not using contraception. Only 30% of those eligible had actually presented for post-coital emergency contraception. However, the uptake of emergency

contraception was similar in the different age groups. CONCLUSION: Effective contraception is important in the prevention of unwanted pregnancies and, although it will not prevent all conceptions, it will contribute significantly to a reduction in unintended pregnancies. This study indicates that there is a need to consider and be sensitive to the different cultural needs of ethnic groups in the development and presentation of future contraceptives.

(92)

Emergency contraception.

Am J Nurs 2000 Sep;100(9):46-8

Morris BJ, Young C

(Department of Nursing, College of Health and Human Services, Southeast Missouri State University, Cape Girardeau, USA.)

HISTORICAL ARTICLE

(93)

Informed consent for emergency contraception: variability in hospital care of rape victims.

Am J Public Health 2000 Sep;90(9):1372-6

Smugar SS, Spina BJ, Merz JF

Medical Center, Philadelphia, USA.

Abstract:

There is growing concern that rape victims are not provided with emergency contraceptives in many hospital emergency rooms, particularly in Catholic hospitals. In a small pilot study, we examined policies and practices relating to providing information, prescriptions, and pregnancy prophylaxis in emergency rooms. We held structured telephone interviews with emergency department personnel in 58 large urban hospitals, including 28 Catholic hospitals, from across the United States. Our results showed that some Catholic hospitals have policies that prohibit the discussion of emergency contraceptives with rape victims, and in some of these hospitals, a victim would learn about the treatment only by asking. Such policies and practices are contrary to Catholic teaching. More seriously, they undermine a victim's right to information about her treatment options and jeopardize physicians' fiduciary responsibility to act in their patients' best interests. We suggest that institutions must reevaluate their restrictive policies. If they fail to do so, we believe that state legislation requiring hospitals to meet the standard of care for treatment of rape victims is appropriate.

(94)

Emergency contraception.

Med Pregl 2000 Sep-Oct;53(9-10):510-2

Draca P.

INTRODUCTION: The aim of this study was to point to the significance of emergency contraception following unsafe sexual intercourse. This method of contraception has been in use since the middle sixties, although in our country it is not applied very often. Indications for emergency contraception comprise every

woman who experiences contraceptive failure or those not using any common contraception for any reason. MATERIAL AND METHODS: Emergency contraceptive devices are most often applied either in combination with estrogen and progesterone or only progesterone in high dosage (0.25 mg levonorgestrel and 50 mg ethinyl-estradiol) during 72 hours after the intercourse and a repeated dose 12 hours later. CONCLUSION: Emergency contraception is recommended as a single procedure. If used several times during a year, the risk of unwanted pregnancy increases. The mechanism of effect of emergency contraception depends on the timing during menstrual cycle; it can prevent ovulation, fertilization or implantation. Emergency contraception does not cause abortion and it is not effective if the process of implantation has started. Unwanted side-effects are not known.

(95)

Emergency hormonal contraception in France in 2000.

Gynecol Obstet Fertil 2000 Oct;28(10):709-10

Aubeny E.

Editorial

(96)

Levonelle-2 for emergency contraception.

Drug Ther Bull 2000 Oct;38(10):75-7

Abstract:

About 190,000 therapeutic terminations of pregnancy occur in the UK each year. Many of these could be prevented by the use of emergency contraception. We have previously discussed the use of combined hormonal emergency contraception. Now, a progestogen-only emergency contraceptive, levonorgestrel in the form of [symbol: see text]Levonelle-2 (Schering Health), has been licensed in the UK. The manufacturer claims that the treatment offers "unsurpassed efficacy in oral emergency contraception" with "significantly less nausea and vomiting than combined oral emergency contraception". We investigate these claims and discuss whether Levonelle-2 is an advance in emergency contraception.

(97)

Experience with self-administered emergency contraception in a low-income, inner-city family planning program.

J Reprod Med 2000 Oct;45(10):827-30

Endres LK, Beshara M, Sondheimer S

(Department of Obstetrics and Gynecology, University of Pennsylvania, Philadelphia, USA.)
lendres@juno.com

OBJECTIVE: To evaluate women's use, knowledge of and attitudes toward self-administered emergency contraceptive pills (ECP) at the University of Pennsylvania family planning clinic (FPC). STUDY DESIGN: The University of Pennsylvania FPC is a Title X, publicly funded clinic serving urban, low-income women. All women attending the clinic were offered ECP packets. Exclusion criteria for ECP were current pregnancy or newly diagnosed hypertension. Women signed consent forms and were given specific instructions on using ECP with the standard Yuzpe method. Women were contacted for a phone interview after they had the ECP packets at home for six to eight months. RESULTS: One hundred ninety-two women received the ECP

packets. Forty-eight were contacted and completed the survey. One hundred forty-four women had moved, no longer had phone service or were unreachable after three or more attempts. Eleven of the 48 women (22.9%) used the ECP, but only 2 of 11 (18.2%) took the pills correctly. One of these two women became pregnant. Of the women who had not used the ECP packets, only 25 of 37 (67.6%) could locate them, and only 9 of 37 (24%) could recall how to use them correctly. Four of 37 (10.8%) experienced an unplanned pregnancy. CONCLUSION: Emergency contraception utilization was far lower than anticipated, suggesting that ready access is not the only issue. Many of the women did not administer ECP correctly or could not state how they would use it in the future despite extensive instruction. Patients will require new and creative approaches to encourage their appropriate use of emergency contraception.

(98)

The use of progesterone antagonists and progesterone receptor modulators in contraception.

Steroids 2000 Oct-Nov;65(10-11):817-23

Spitz IM, Van Look PF, Coelingh Bennink HJ.

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Abstract:

Progesterone antagonists (PAs) and progesterone receptor modulators (PRMs) have contraceptive potential by suppressing follicular development, delaying the surge of luteinizing hormone (LH), retarding endometrial maturation, and promoting endometrial bleeding. Mifepristone, in daily doses of 2-10 mg, blocks the LH surge and ovulation. Many of the studies were conducted in women not at risk of pregnancy, and thus the contraceptive efficacy is not yet known. Nevertheless, there is evidence that daily doses of 2 or 5 mg of mifepristone have contraceptive potential. Because of anovulation, there may be an unopposed estrogen effect on the endometrium, although this risk may be mitigated by the noncompetitive anti-estrogenic activity exhibited by both PAs and PRMs. Low doses of PAs and PRMs, which do not affect ovulation, retard endometrial maturation, indicating that the endometrium is exquisitely sensitive to these compounds. This raises the prospect of endometrial contraception, i.e. prevention of endometrial maturation without disturbing ovulation or producing alterations in bleeding patterns. This approach works well in monkeys but was not found to be very promising when given to women not using contraception. On the other hand, 200 mg mifepristone administered 48 h after the LH surge, which has minimal or no effect on ovulation and bleeding patterns, is an effective contraceptive; yet, it is not a practical approach to contraception. Late luteal phase administration of mifepristone produces menstrual bleeding. However, when mifepristone was administered every month at the end of the cycle either alone or together with prostaglandins, it was not very effective in preventing pregnancy. In contrast, a mifepristone-prostaglandin combination has been shown to be a very effective treatment for occasional menstrual regulation, with vaginal bleeding induced in 98% of pregnant women, with menses delay of 11 days or less. Mifepristone is an excellent agent for emergency contraception when used within 120 h of unprotected intercourse. It is also possible that PAs and PRMs may be used to reduce the occurrence of bleeding irregularities induced by progestin-only contraceptive methods. Both classes of progesterone receptor ligands may also have contraceptive efficacy by having a pharmacological effect on the embryo or altering tubal transport or other aspects of tubal physiology.

REVIEW; TUTORIAL

(99)

Effect of the Yuzpe regimen of emergency contraception on markers of endometrial receptivity.

Hum Reprod 2000 Nov;15(11):2351-5

Raymond EG, Lovely LP, Chen-Mok M, Seppala M, Kurman RJ, Lessey BA

(Family Health International, Research Triangle Park, NC, Division of Reproductive Endocrinology and Infertility, Department of Obstetrics and Gynecology, University of North Carolina, Chapel Hill, NC, USA, Department of Obstetrics and Gynecology, Unive.)

Abstract:

This exploratory study was designed to determine whether treatment with the Yuzpe regimen of emergency contraception altered endometrial integrin expression or other markers of uterine receptivity. Nineteen parous women were followed for two menstrual cycles. In the second cycle, each participant took 100 mg ethinyl oestradiol and 1 mg norgestrel on the day of the urinary luteinizing hormone (LH) surge and repeated the dose 12 h later. In both cycles, endometrial biopsy, phlebotomy and vaginal sonogram were performed 8-10 days after the urinary LH surge. No significant difference was found between untreated and treated cycles in most measures of endometrial histology or in endometrial expression of beta3 integrin subunit, leukaemia inhibitory factor, glycodelin, or progesterone receptors assessed by immunohistochemical techniques. Five statistically significant changes were noted in treated cycles: a reduction in endometrial MUC-1 expression, an increase in endometrial oestrogen receptor, lower luteal phase serum oestrogen concentration, reduced endometrial thickness, and greater proportion of glandular supranuclear vacuoles. The relationship of these findings to the contraceptive action of the Yuzpe regimen is unclear.

(100)

Emergency postcoital contraception.

Am Fam Physician 2000 Nov 15;62(10):2287-92

Wertheimer RE

Department of Family Medicine and Community Health, UMass Memorial Medical Center, University of Massachusetts Medical School, Worcester 01605, USA.

Abstract:

Emergency postcoital contraception, a method used to prevent pregnancy after unprotected sexual intercourse, is a highly effective but underutilized birth control option. Two hormone regimens, ethinyl estradiol (100 microg) with levonorgestrel (0.5 mg) or high-dose levonorgestrel (0.75 mg), given within 72 hours of intercourse and repeated 12 hours later, are available for this purpose. These regimens are packaged as Food and Drug Administration labeled, dedicated products or can be adapted for use from standard oral contraceptive pills. Emergency postcoital contraception should be considered as a primary prevention health service to women of childbearing age.

(101)

Emergency contraception: still not too late.

Am Fam Physician 2000 Nov 15;62(10):2222, 2225-6

Wellbery C

EDITORIAL

(102)

Informed consent and emergency contraception.

Am Fam Physician 2000 Nov 15;62(10):2219-20

McGaughran AL

EDITORIAL

(103)

Ectopic gestation following emergency contraceptive pill administration.

Contraception 2000 Nov;62(5):275-6

Nielsen CL, Miller L.

University of Washington School of Medicine, Seattle, WA, USA.

Abstract:

Emergency contraceptive pill prescription following rape is common. We report a case of ectopic gestation after emergency contraceptive pill failure and review the literature on this rare complication. A 26-year-old woman with a normal menstrual period 2 weeks before was administered an emergency contraceptive pill 8 hours after a single sexual assault. The assault was her only sexual activity before and after the emergency contraceptive pill use. Forty-six days following the assault, the patient presented with a right ampullary tubal pregnancy of 59 days gestation and underwent emergent surgery for ectopic gestation. To prevent a delay in the diagnosis of ectopic pregnancy, we recommend that providers and the package insert advise women, that ectopic gestation can occur with emergency contraceptive pill failure.

(104)

Emergency contraception and the ethics of discussing it prior to the emergency.

Womens Health Issues 2000 Nov-Dec;10(6):312-6

Bell BS, Mahowald MB

(Pritzker School of Medicine, University of Chicago, Chicago, Illinois, USA.)

Abstract:

Illustrative cases are considered to show that, on ethical grounds, emergency contraception should be routinely included in discussions with patients about alternative methods of contraception.

(105)

Apparent interaction between warfarin and levonorgestrel used for emergency contraception.

BMJ 2000 Dec 2;321(7273):1382

Ellison J, Thomson AJ, Greer IA, Walker ID

(Department of Obstetrics and Gynaecology).

(106)

Emergency contraception.

Obstet Gynecol Clin North Am 2000 Dec;27(4):817-39, vii

LaValleur J

(Department of Obstetrics, Gynecology, and Women's Health, University of Minnesota Medical School, Minneapolis, USA). laval001@tc.umn.edu

Abstract:

The time has come for emergency contraception. It is highly underused worldwide, and especially in the United States, where patient and physician awareness remain low. There are several highly effective, well-tolerated methods that can be used to prevent undesired pregnancy after unprotected intercourse. This article discusses these methods, their method of action, effectiveness, safety, and tolerability.

(107)

Knowledge and attitudes about emergency contraception in a military population.

Obstet Gynecol 2000 Dec;96(6):921-5

van Royen AR, Calvin CK, Lightner CR

(Department of Obstetrics and Gynecology, Wilford Hall Medical Center, Lackland Air Force Base, Texas, USA.)

Objective: To assess knowledge and attitudes about reproductive issues and emergency contraception among active duty military members. Methods: A survey was distributed to 302 active duty members of the United States Air Force. Descriptive and Pearson chi(2) statistical analyses were used to evaluate findings. Results: There was a general lack of knowledge about reproductive issues and the Yuzpe emergency contraception method. Eighty-five percent of respondents were sexually active, but only 62% used birth control. Only 40% knew when pregnancy was most likely to occur. Sixty-four percent had heard of emergency contraception, but only 15% were aware of the correct time to take it. Fifty-five percent said they would use emergency contraception if needed, with younger or unmarried individuals most willing. Conclusion: Knowledge deficits must be addressed to keep women deployable. Educational materials and emergency contraception kits should be standard issue items. That might prevent unwanted pregnancies and produce significant savings in reproductive health and emotional costs.

(108)

Patterns of prescription of PC4 by general practitioners in England and Wales.

Eur J Contracept Reprod Health Care 2000 Dec;5(4):241-7

Ineichen B, Logie J, Rowlands S, Lawrenson R.
Postgraduate Medical School, University of Surrey, Guildford, UK.

OBJECTIVE: To study the pattern of general practitioner prescribing of PC4, the most commonly used method of hormonal emergency contraception, in England and Wales. METHOD: The UK General Practice Research Database was used to identify, from a total population of 4.2 million people on the lists of contributing practices, all women aged 10-44 years who were prescribed PC4. Rates of prescribing were calculated to produce rates over time by age group, by day of week and month of year, and by region.

RESULTS: The rate for PC4 prescribing rose from about 1.5 per 1,000 women per month in 1992 to about 3.0 in 1995, then remained relatively constant until 1998. Rates were highest among 15-19-year-old women and next highest among those aged 20-24 years. Rates were higher in Wales than in each of the English regions. Excesses of prescribing took place in the summer months and between Saturdays and Mondays. **CONCLUSION:** Reasons for the increase in PC4 prescribing rates in the early years of the study are unclear, although increasing knowledge of the technique among the population may have contributed. There was no evidence of an increase in prescribing following the pill scare of October 1995, although there was an increase some months earlier. The concentration of requests at weekends suggests the need for weekend access to emergency contraception. The summer peak may also indicate a heightened need in holiday areas at that time.

(109)

Teenage pregnancy: whose problem is it?

Fam Pract 2000 Dec;17(6):522-8

Jewell D, Tacchi J, Donovan J.

(Division of Primary Health Care, University of Bristol, Bristol, UK.)

BACKGROUND: The UK has the highest rates of teenage conception in Europe. Teenage conception has been identified in medical literature as a problem for society and teenagers. However, little attempt has been made to see it from the perspective of the teenagers themselves. **OBJECTIVE:** To explore teenage women's attitudes to sexual health, contraception and pregnancy. **METHODS:** Ethnographic qualitative study based on in-depth interviews and participant observation. The study took place in young mothers' groups, young persons' clinics and general practices in Bristol. Subjects were 34 young women between the ages of 16 and 20, sampled purposefully in two groups to include young mothers and never-pregnant young women from advantaged and disadvantaged socioeconomic backgrounds. **RESULTS:** The two groups did not differ in their use of contraception at first intercourse. Young women from more socioeconomically advantaged backgrounds felt that motherhood would not be acceptable to them, but were more tolerant to others who became young mothers. The pregnant/ young mothers revealed more difficulties getting access to reliable contraceptive services, and dissatisfaction with sex education in schools. The pregnant/young mothers found abortion to be less acceptable than the more socially advantaged group. Both groups reported sexual behaviour that involved risks of becoming pregnant, but the more socially advantaged group were more likely to use emergency contraception. **CONCLUSIONS:** The study demonstrates the importance of taking the views of young people into account when planning both sex education and the provision of contraceptive services.

(110)

Drug Points: Apparent interaction between warfarin and levonorgestrel used for emergency contraception.

BMJ 2000 Dec 2;321(7273):1382

Ellison J, Thomson AJ, Greer IA, Walker ID.

(Department of Obstetrics and Gynaecology, Glasgow Royal Infirmary, Glasgow G31 2ER, UK.)

(111)

Improving access to emergency contraception.

BMJ 2001 Jan 27;322(7280):186-7

Harrison-Woolrych M, Howe J, Smith C.

Publication Types:

Editorial

(112)

Mifepristone as a late post-coital contraceptive.

Human Reprod 2001 Jan; 16(1): 72-75

Ashok PW, Wagaarachchi PT, Flett GM, Templeton A.

(Department of Obstetrics and Gynaecology, University of Aberdeen, Aberdeen Maternity Hospital, Cornhill Road, Aberdeen, AB25 2ZL, UK). ashok@abdn.ac.uk

Abstract:

This study was undertaken to assess the efficacy of mifepristone as a post-coital contraceptive beyond 72 h and up to 5 days in women who found the intrauterine contraceptive device (IUCD) unacceptable. During a 2 year period 219 consecutive women fulfilling the inclusion criteria and presenting late for emergency contraception were approached and offered a choice of methods. Fifteen (6.8%) women wished to have the IUCD fitted, but 204 (93.2%) who found this unacceptable were offered and accepted mifepristone 200 mg. In one woman there was a technical problem fitting the IUCD and mifepristone was administered. Women who had mifepristone were younger (mean age 21.4 versus 26.9 years, $P = 0.004$) and more likely to be nulliparous (81 versus 25 %, $P < 0.001$) than the IUCD group. A total of 155 (75.6%) women who had mifepristone and all 14 who had the coil fitted were followed up. There were no true failures in either group. There was one user failure in the mifepristone group, where pregnancy occurred from an act of intercourse subsequent to treatment, giving a crude pregnancy rate of 0.65%. Mifepristone prevented 85% of expected pregnancies. Most women find the IUCD an unacceptable method of post-coital contraception. Mifepristone is an effective late post-coital contraceptive, which can be offered to women who decline the IUCD.

(113)

The emergency contraception collaborative prescribing experience in Washington State.

J. Am Pharm Assoc (Wash) 2001 Jan-Feb;41(1):60-6

Sommers SD, Chaiyakunapruk N, Gardner JS, Winkler J.

Group Health Cooperative, Puget Sound, Wash., USA.

OBJECTIVE: To describe how prescribers and pharmacists view the Emergency Contraceptive Pills (ECP) program, and to evaluate pharmacists' performance through the use of a consumer survey. **DESIGN:** Self-administered provider satisfaction surveys were mailed 6 months after the program's inception. Consumer satisfaction surveys were distributed at the point of ECP service for

return by mail. **SETTING:** The program encouraged pharmacists and prescribers in western Washington to enter into collaborative prescribing agreements, increasing consumers' access to ECP. **PATIENTS OR OTHER PARTICIPANTS:** Pharmacists who had attended ECP training sessions, prescribers who had authorized pharmacists to prescribe ECP, and women who had been prescribed ECP by pharmacists. **MAIN OUTCOME MEASURES:** Providers' reasons for participating, attitudes toward the ECP program, and

experiences with ECP as a result of the program; feedback from women receiving ECP from pharmacists. RESULTS: 309 pharmacist surveys and 55 prescriber surveys were sent, of which 159 (51%) and 27 (49%), respectively, were returned. Meeting patient needs and having a professional responsibility to participate were commonly reported reasons for ECP program involvement. Both pharmacists and prescribers (92%) reported being "satisfied" or "very satisfied" with their prescribing agreements. On the 470 consumer surveys returned out of 7,000 distributed (6.5%), pharmacists were rated highly satisfactory for their interactions with patients and the quality of information about ECP use given, but less satisfactory for information about adverse effects, recognition and follow-up of ECP failure, and regular contraceptive methods. CONCLUSION: All participants expressed satisfaction with the ECP program. This example should support the initiation of similar programs in other states.

(114)

Emergency contraception: pediatricians' knowledge, attitudes, and opinions.

Pediatrics 2001 Feb;107(2):287-92

(Golden NH, Seigel WM, Fisher M, Schneider M, Quijano E, Suss A, Bergeson R, Seitz M, Saunders D. Schneider Children's Hospital, Albert Einstein College of Medicine, New Hyde Park, New York 10040, USA.) golden@lij.edu

Abstract:

Emergency contraception (EC) is the use of a method of contraception after unprotected intercourse to prevent unintended pregnancy. Although first described over 20 years ago, physician awareness of EC has been limited and many feel uncomfortable prescribing it. OBJECTIVE: To assess the knowledge, attitudes, and opinions of practicing pediatricians regarding the use of EC in adolescents. METHODS: An anonymous questionnaire was mailed to all 954 active members of New York Chapter 2, District II of the American Academy of Pediatrics. The questionnaire assessed basic knowledge, attitudes, and opinions regarding EC in adolescents. Data were analyzed by physician age, gender, year completed residency, and practice type. RESULTS: Two hundred thirty-three practicing pediatricians (24.4%) completed the survey. Of the respondents, 23.7% had been asked to prescribe EC to an adolescent and 49% of these cases involved a rape victim. Only 16.7% of pediatricians routinely counsel adolescent patients about the availability of EC, with female pediatricians more likely to do so. Most respondents (72.9%) were unable to identify any of the Food and Drug Administration-approved methods of EC. Only 27.9% correctly identified the timing for its initiation and only 31.6% of respondents felt comfortable prescribing EC. Inexperience with use was cited as the primary reason for not prescribing EC by 70% of respondents. Twelve percent cited moral or religious reasons and 17% were concerned about teratogenic effects. There were no differences in comfort level based on age, gender, or practice type. Twenty-two percent of respondents believed that providing EC encourages adolescent risk-taking behavior and 52.4% would restrict the number of times they would dispense EC to an individual patient. A minority of respondents (17%) believed that adolescents should have EC available at home to use if necessary and only 19.6% believed that EC should be available without a prescription. The vast majority (87.5%) were interested in learning more about EC. CONCLUSIONS: Despite the safety and efficacy of EC, the low rate of use is of concern. Pediatricians are being confronted with the decision to prescribe EC but do not feel comfortable prescribing it because of inadequate training in its use. Practicing pediatricians are aware of their lack of experience and are interested in improving their knowledge base.

(115)

Evaluation of a media campaign to increase knowledge about emergency contraception.

Contraception 2001 Feb;63(2):81-7

Trussell J, Koenig J, Vaughan B, Stewart F.

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USA.trussell@princeton.edu

Abstract:

Our objective was to evaluate a media campaign designed to increase knowledge about emergency contraception. Random telephone surveys were conducted before and after the campaign to measure changes in knowledge about emergency contraception. Change in the volume of calls to the Emergency Contraception Hotline (1-888-NOT-2-LATE) was a secondary measure of impact. Significant increases occurred in the proportions of women who knew that something could be done after intercourse to prevent pregnancy, who knew the term emergency contraception, who knew of the 72-h time limit, and who had heard of the Hotline. In addition, the number of calls to the Hotline increased substantially. A public education media campaign resulted in significant increases in knowledge about emergency contraception. The first contraception advertisement ever shown on television did not provoke controversy.

(116)

Deliverance of emergency contraception, in 1988, in family planning and education clinics (FPEC) of Val de Marne.

Gynecol Obstet Fertil 2001 Feb;29(2):129-36

Prudhomme M, Perriot Y, Leroux MC.

Service de protection maternelle et infantile, conseil general du Val de Marne, 13-15, rue Gustave-Eiffel, 94011 Creteil, France.

OBJECTIVES: To facilitate access to emergency contraception (EC). To allow the nurses in the family planning clinics to deliver it during the doctor's absence. **METHODS:** For one year, 1998, 1102 women requested EC in the 38 family planning clinics participating in the study. This study evaluated the utilisers and the circumstances under which dispensation occurred. **RESULTS:** The users of EC were young, 45% under 18 years and 90% under 25 years. There was a marked difference between the contraception the women declared they used and that which they actually did during their last episode of sexual intercourse. Women requested EC in case of condom breakage or slipping (49%), forgotten pill (8%), or after unprotected intercourse (43%). Nurses personally received 809 requests for EC, and 293 women were received by the family planning doctor. In 77% of the cases, EC was given by the nurses, and for the others after medical opinion. But only 7% had a medical "problem" (contraindications to estrogen-progestin, or cycle disorder). Among the 823 women for whom information was obtained, 22 unwanted pregnancies were observed, 18 of these patients decided to have an abortion. 97.3% efficacy. **CONCLUSION:** Making EC more easily available in family planning clinics with dispensation by nurses does no harm and may reduce the rate of unwanted pregnancy.

(117)

Emergency contraception in Chile.

Lancet 2001 Mar 10;357(9258):809

Meirik O.

Letter

(118)

Routine provision of emergency contraception to teens and subsequent condom use: a preliminary study.

J Adolesc Health 2001 Mar;28(3):165-6

Roye CF.

(119)

The effects of peri-ovulatory administration of levonorgestrel on the menstrual cycle.

Contraception 2001 Mar;63(3):123-9

Hapangama D, Glasier AF, Baird DT.

(Contraceptive Development Network, Department of Reproductive and Development Sciences, The University of Edinburgh, Centre of Reproductive Biology, EH3 9ET, Edinburgh, Scotland, United Kingdom.)

Abstract:

Levonorgestrel (LNG) 0.75 mg administered 12 h apart within 72 h of unprotected coitus, is an established method of emergency contraception (EC). The mechanism of action of LNG used in this manner is unknown. We administered LNG 0.75 mg twice immediately before ovulation, to test the hypothesis that LNG acts as an emergency contraceptive by abolishing the pre-ovulatory luteinizing hormone (LH) surge and thereby delaying ovulation. Twelve women took LNG on or before the day of the first significant rise in urinary LH in 12 cycles. In four women, the LH peak and the onset of next menses were significantly delayed (delay of 16.8 days (SD +/- 8.7) from the day of mean LH peak in placebo cycles). One woman did not ovulate at all, despite a normal LH peak and cycle length. In the remaining eight women, LNG did not affect ovulation or the cycle length, but the length of the luteal phase and the total luteal phase LH concentrations were significantly reduced. We suggest that LNG acts as an emergency contraceptive by other mechanisms as well as delaying the LH surge and interfering with ovulation.

(120)

Mechanism of action of hormonal preparations used for emergency contraception: a review of the literature.

Contraception 2001 Mar;63(3):111-21

Croxatto HB, Devoto L, Durand M, Ezcurra E, Larrea F, Nagle C, Ortiz ME, Vantman D, Vega M, von Hertzen H.

(Instituto Chileno de Medicina Reproductiva, Santiago, Chile)

(121)

The next step for emergency contraception: Over-the-counter availability.

Clin Excell Nurse Pract 2001 Mar;5(2):73-9

O'Callaghan MA, Andrist LC.

(Nurse Practitioner, Private Practice, Massachusetts.)

Abstract:

Emergency contraception to prevent pregnancy after episodes of unprotected sexual intercourse has existed since ancient times. Modern medicine began to use hormonal methods in the 1960s, and today emergency contraception is used regularly in many countries. In the United States, providers do not routinely prescribe it, nor do they adequately inform their patients that it is available. This occurs even though sufficient information exists on the safety and efficacy of this method. Because the effectiveness of emergency contraceptive pills relies heavily on prompt administration, better access for patients is essential. Recently, proponents of emergency contraception have attempted to better inform the public of this resource. In addition, two oral contraceptive products are now available and marketed specifically for emergency contraception. The purpose of this article is to discuss the safety and efficacy of emergency contraceptive pills and the potential for them to become available without a prescription.

(122)

Knowledge of emergency contraception among pharmacists and doctors in Durban, South Africa.

Eur J Contracept Reprod Health Care 2001 Mar;6(1):21-6

Hariparsad N.

(School of Pharmacy and Pharmacology, University of Durban-Westville, South Africa.)

OBJECTIVE: To determine the level of knowledge of emergency contraception among private-sector pharmacists and doctors. **METHOD:** This hand-delivered, confidential questionnaire survey was undertaken in North and South Central Durban, Kwazulu-Natal, South Africa. The main outcome measures were frequency of demand for emergency contraception and knowledge of its dosing schedule, side-effects and contraindications. **RESULTS:** Ninety-six per cent of pharmacists and 93% of doctors had received requests for emergency contraceptive pills within the past year. Thirty-two per cent of pharmacists and 28% of doctors prescribed the Yuzpe regimen correctly. Only 23 (27%) doctors and 25 (22%) pharmacists were able to identify three common side-effects associated with emergency contraceptive pills. Forty-six per cent of pharmacists and 49% of doctors correctly indicated that there are no absolute contraindications to emergency contraceptive pills other than a contraindication to contraceptive pills. Fifty-four per cent of pharmacists and 35% of doctors agreed that the multiple use of emergency contraceptive pills is risky. **CONCLUSION:** There is an urgent need to improve the knowledge of health-care workers regarding emergency contraception, which forms an important back-up method when existing contraception fails or is not used.

(123)

Bringing emergency contraception to American women: the history and remaining challenges.

Womens Health Issues 2001 Mar-Apr;11(2):80-6

Coeytaux F, Pillsbury B.

Pacific Institute for Women's Health, Los Angeles, California, USA

Abstract:

Emergency contraception has been called "America's best-kept secret." This article chronicles what it took to move it from secret to the pharmacy shelf. The fact that an emergency contraception product is available today in many pharmacies is indeed a major accomplishment. However, the job is not yet done. The shelf it needs to be found on is not just the pharmacists' shelf, behind the counter-but the shelf in the medicine cabinet in millions of homes everywhere, like burn medicine, "just in case."

(124)

Swedish teenagers' attitudes toward the emergency contraceptive pill.

J Adolesc Health 2001 Apr;28(4):313-8

Haggstrom-Nordin E, Tyden T.

Department of Women's and Children's Health, Uppsala University and Center of Clinical Research, Central Hospital, Vasteras, Sweden.

PURPOSE: To explore knowledge, attitudes toward, and experience with, the emergency contraceptive pill (ECP) among teenagers in Sweden. **METHODS:** A questionnaire with 23 questions concerning the students' demographics, knowledge of, attitudes toward, and experience of the ECP was delivered to a random sample of 20 classes in senior high school in two medium-sized cities in Sweden. The participation rate was 100% (n = 408). Differences in responses between teenagers in the two cities, boys and girls, theoretical and practical classes, or native Swedish and immigrant teenagers were calculated with the Chi-square test. **RESULTS:** The mean age was 16.5 years. Almost half (45.4%) of the teenagers had had sexual intercourse and of those, 28.3% stated that they themselves or their partner had used ECP. Four of five teenagers knew about ECP and where to obtain it if necessary. Many teenagers (67.3%) also knew that ECP prevented implantation. The main sources of information about ECP were youth clinics (n = 179) and friends (n = 159). The attitude toward using ECP in an emergency situation was positive, but the teenagers, especially girls, were restrictive as to whether ECP should be available without a prescription. The girls believed ECP could be used much more, and two-thirds of both sexes thought it could lead to negligence with ongoing contraception. Seventy-seven percent of teenagers preferred turning to a youth clinic when in need of ECP. One in four believed that concerns for side effects could deter them from using ECP. **CONCLUSIONS:** Based on the results in the present study, the importance of counseling in this situation is confirmed. The awareness about ECP was good, but teenagers also expressed concerns about side effects. The girls were more hesitant than the boys about having ECP available over the counter.

(125)

Adverse reactions and emergency contraception.

Lancet 2001 Apr 14;357(9263):1203

Grant EC.

Letter

(126)

Cost savings from emergency contraceptive pills in Canada.

Obstet Gynecol 2001 May;97(5 Pt 1):789-93

Trussell J, Wiebe E, Shochet T, Guilbert E.

(Office of Population Research, Princeton University, Princeton, New Jersey 08544, USA.)
trussell@princeton.edu

OBJECTIVE: To estimate cost savings from emergency contraceptive pills in Canada. **METHODS:** We modeled cost savings when a single emergency contraceptive treatment was provided after unprotected

intercourse and when women were provided emergency contraceptive pills in advance. RESULTS: Each dollar spent on a single treatment saved \$1.19--\$2.35 (in Canadian currency), depending on the regimen and on assumptions about savings from costs avoided by preventing mistimed births. The dedicated products Preven (Shire Canada, Inc., Oakville, Ontario) and Plan B (Paladin Labs, Inc., Montreal) were cost-saving even under the least favorable assumption that mistimed births prevented today occur 2 years later. Each dollar spent on advance provision of Preven saved \$1.24--\$12.23, depending on the regular contraception method, on how consistently emergency contraception was used when needed, and on whether mistimed births were averted forever or simply delayed. Plan B was almost always cost-saving, although less so. CONCLUSION: Emergency contraception was cost-saving whether provided when the emergency occurred or in advance to be used as needed. More extensive use of emergency contraception could save considerable medical costs by reducing unintended pregnancies.

(127)

Emergency contraception from pharmacists misses opportunity.

BMJ 2001 May 19;322(7296):1245

Stammers T.

Letter

(128)

Emergency contraception. Attitudes and practices of primary care doctors in North Carolina.

N C Med J 2001 May-Jun;62(3):158-62

Lindsey JN.

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(129)

Quick Uptakes: Promoting Emergency Contraception.

JAMA 2001 Jun 27;285(24):3080

Mitka M.

(129)

Emergency contraception. Summary of the Society of Obstetricians and Gynaecologists of Canada's clinical practice guidelines.

Can Fam Physician 2001 Jun;47:1261-3, 1267-9

Dunn S, Davis V.

(Bay Centre for Birth Control, Sunnybrook and Women's College Health Sciences Centre, Toronto, Ont.)

(130)

Emergency contraception and family physicians. An ounce of prevention when it really counts.

Can Fam Physician 2001 Jun;47:1159-60, 1166-8

Dunn S.

Editorial

(131)

Pilot program tests distributing emergency contraception without a prescription.

West J Med 2001 Jun;174(6):381

News

(132)

Changes in providers' views and practices about emergency contraception with education.

Obstet Gynecol 2001 Jun;97(6):942-6

Beckman LJ, Harvey SM, Sherman CA, Petitti DB.

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OBJECTIVE: To assess changes in the prescribing practices, knowledge, attitudes, and perceptions of health care providers after an educational program about emergency contraception. METHODS: Health care providers completed self-administered questionnaires before and 1 year after full implementation of the project. The 102 providers who completed both questionnaires were physicians (64%) and mid-level professionals from 13 San Diego County Kaiser Permanente medical offices working in departments such as obstetrics and gynecology, primary care, and emergency medicine. RESULTS: The frequency of prescription for emergency contraceptive pills increased significantly from baseline to follow-up. There was an increase of almost 20% in the percentage who prescribed emergency contraception at least once a year. Knowledge also improved significantly, and perceptions of barriers to prescribing emergency contraceptive pills within the health maintenance organization decreased significantly. In contrast, attitudes about emergency contraception showed little change. CONCLUSION: This study suggests that providers who participate in in-service training and other aspects of a demonstration project show changes in perceptions, knowledge, and behavior. However, findings also suggest that significant gaps remain in knowledge about medications, side effects, and mode of action. It is likely that many providers in other health care settings also need additional information and training concerning protocols of emergency contraception provision and its modes of action and effects.

(133)

Emergency contraception over-the-counter: the medical and legal imperatives.

Obstet Gynecol 2001 Jul;98(1):151-5

Grimes DA, Raymond EG, Scott Jones B.

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Abstract:

Requiring a physician's prescription for hormonal emergency contraceptive pills makes no sense. Unintended pregnancies remain endemic in the United States, and wider use of emergency contraceptive pills could substantially help. However, the prescription requirement poses an unnecessary barrier to prompt, effective use of this preventive therapy. According to the Durham-Humphrey Amendment of 1951, the default option for all new drugs is, in principle, over-the-counter, unless a drug is addictive or dangerous when self-administered. Clearly, hormonal emergency contraception is neither of these. Emergency contraceptive pills meet all the customary criteria for over-the-counter use: low toxicity, no potential for overdose or addiction, no teratogenicity, no need for medical screening, self-identification of the need, uniform dosage, and no important drug interactions. The Food and Drug Administration is authorized, and, by its own regulations, should be required to switch hormonal emergency contraception to over-the-counter status without delay. The current prescription requirement is not only gratuitous but also harmful to women's health because it impedes access to this important therapy.

(134)

Levonorgestrel-only emergency contraception: real-world tolerance and efficacy.

Contraception 2001 Jul;64(1):17-21

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Abstract:

Levonorgestrel-only emergency contraception was introduced onto the market in France in May 1999 on the heels of a large-scale clinical trial demonstrating its enhanced efficacy and tolerance over the combined estrogen-progestin reference method. To evaluate the product's real-world tolerance and efficacy in the more than 20 months that it has been on the market, a retrospective study was performed among large-scale prescribers in France. One hundred physicians were asked to complete a written questionnaire outlining their practices with regards to their prescription of the product as well as their knowledge and evaluation of the product's tolerance and efficacy. Results from 82 respondents representing over 2,000 administrations demonstrate that physicians judge levonorgestrel-only emergency contraception to be very well tolerated and without unexpected side effects. Further, respondents report a pregnancy rate similar to that chronicled in the large-scale clinical trial (less than 3%), thus substantiating conclusions regarding the product's considerable efficacy and its potential for reducing the rate of unintended pregnancies.

(135)

Young women requesting emergency contraception are, despite contraceptive counseling, a high risk group for new unintended pregnancies.

Contraception 2001 Jul;64(1):23-7

Falk G, Falk L, Hanson U, Milsom I.

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Abstract:

Since its introduction in Sweden in 1994, emergency contraception has become a welcome addition to the campaign against unwanted pregnancy. In addition to an unplanned pregnancy, unprotected sexual intercourse may also involve the risk of contracting sexually transmitted diseases (STD). The aim of this study was to

assess the short- and long-term risk of unintended pregnancy and to determine the frequency of chlamydia infections in women receiving emergency contraception. Between September 1998 and February 1999 young women aged 15-25 years had the opportunity to obtain emergency contraception (Yuzpe method) at a youth clinic in the city of Orebro where the opening hours were extended to include Saturdays and Sundays. A follow-up visit 3 weeks after treatment, which included contraceptive counseling, was offered to all participants. At both visits, a pregnancy test and a chlamydia test were performed, and the women completed a questionnaire. After the initial visit, the young women were monitored for new pregnancies during the following 12 months. One pregnancy occurred in the 134 young women who received emergency contraception during the study period. None of the women had a positive chlamydia test. Of those requesting emergency contraception, 54% did so because no contraception was used, 32% because of a ruptured condom, 11% because of missed oral contraceptives (OC), and 5% had mixed reasons. At long-term follow-up 1 year after the initial visit, 10 of the 134 young women had experienced an unplanned pregnancy that terminated in legal abortion in 9 women. All these women had either started and terminated OC or had never commenced the prescribed OC. Young women who request emergency contraception are, despite a planned follow-up with contraceptive counseling, a high risk group for new unintended pregnancies. In Sweden they do not seem to be a high risk group for STD.

(136)

Increasing access to emergency contraception through community pharmacies: lessons from Washington State.

Fam Plann Perspect 2001 Jul-Aug;33(4):172-5

Gardner JS, Hutchings J, Fuller TS, Downing D.

(University of Washington Department of Pharmacy, Seattle, USA.)

(137)

Emergency contraception in Brazil: facilitators and barriers

Cad Saude Publica 2001 Jul-Aug;17(4):1031-5

[Article in Portuguese]

Hardy E, Duarte GA, Osis MJ, Arce XE, Possan M.

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Abstract:

A multi-centered qualitative study was conducted in Brazil, Chile, and Mexico to assess the acceptability of emergency contraception both among potential users and possible providers, authorities, and opinion-makers, and to identify (according to participants' perceptions) factors facilitating or hindering the method's use and the most appropriate strategies to disseminate information and provide the method. Data were collected through semi-structured interviews, group interviews, and discussion groups, which were tape-recorded and transcribed. A thematic analysis of this material was conducted. Acceptability of emergency contraception was high among participants, who also felt that there were no barriers towards its acceptance by the population. Participants felt that the method's acceptability would be greater if it were included in reproductive health programs, emphasizing its prescription for emergency situations. Participants highlighted that strategic components in Brazil would be training of providers and inclusion of the method in family planning services.

MULTICENTER STUDY

(138)

Unwanted pregnancy and contraceptive knowledge: identifying vulnerable groups from a randomized controlled trial of educational interventions.

Fam Pract 2001 Aug;18(4):449-53

Little P, Griffin S, Dickson N, Sadler C, Kelly J.
Primary Medical Care Group, University of Southampton, Alder Moor Health Centre, Alder Moor Close, Southampton SO16 5ST, UK.

OBJECTIVES: The aim of this study was to identify predictors of contraceptive pill knowledge and their relationship to educational interventions. **METHODS:** A total of 636 women attending for a follow-up appointment for repeat prescription of the combined oral contraceptive pill with a GP or practice nurse were randomized to receive leaflets (simple summary leaflet or FPA leaflet), advice or neither. Sociodemographic details and contraceptive knowledge were determined using a validated contraceptive knowledge questionnaire sent after 3 months by post. The main outcomes were sociodemographic, contraceptive, attitudinal and educational predictors of knowledge. **RESULTS:** A total of 522 (82%) had complete questionnaires. After controlling for educational intervention and other confounding variables, independent predictors of knowledge were further education (adjusted odds ratio 2.98, 95% confidence interval 1.78-4.99); number of years on the pill (0-5, 6-10, >10 years) 1.0, 0.56 (0.33-0.95) and 0.34 (0.19-0.59), respectively; past emergency contraception (1.87, 1.18-2.97); and importance attached to not falling pregnant (1.83, 1.02-3.29). These predictors are less powerful than the impact of most educational interventions (range of odds ratios for interventions: 1.85-6.81), and there was no evidence of a separate effect of educational intervention in any subgroup, except that leaflets have a larger effect in women who have needed emergency contraception in the past (no past use or simple summary and FPA leaflets, 1.74 and 0.90, respectively; with past use, 3.47 and 3.83; interaction term chi-square 6.92, $P = 0.03$). **CONCLUSION:** Educational interventions are as important as sociodemographic features in determining knowledge. With limited time for full educational interventions in practice, priorities for intervention should be women who have used emergency contraception in the past-who will benefit most-and those on the pill for >5 years or with no further education who are at highest risk due to poor knowledge.

CLINICAL TRIAL; RANDOMIZED CONTROLLED TRIAL

(139)

Emergency contraception with Multiload Cu-375 SL IUD: a multicenter clinical trial.

Contraception 2001 Aug;64(2):107-12

Zhou L, Xiao B.

(National Research Institute for Family Planning, No. 12 Da Hui Si, Hai Dian Qu, Beijing 100081, People's Republic of China.)

Abstract:

The objectives of the present study were to evaluate the efficacy and side effects and the benefits and limitations of inserting Multiload intrauterine device (IUD) for emergency contraception. A total of 1013 women requesting emergency contraception was recruited, among whom 843 were parous women and 170 nulliparous women. Multiload Cu-375 SL IUD was inserted within 120 h after unprotected intercourse. A urine test for pregnancy was performed before IUD insertion to rule out pregnancy. Participants were

followed-up until 1 week after the expected day of the next menstruation. Pregnancy test or ultrasound scanning were performed if menstruation did not return. Efficacy of preventing unplanned pregnancy was calculated. Efficacy and side effects were compared between the parous and nulliparous groups. The results showed that there were two pregnancies, one in each group. The pregnancy rate was 0.2 per 100 women. The efficacy rate of preventing unwanted pregnancy in the parous group was 98.1% and in the nulliparous group 92.4%. The difference was not significant. Removal of IUD because of pain and bleeding was 2.5% in parous women, but was more in the nulliparous group (10.6%). After the return of menstruation, 95.7% of parous women and 80% of nulliparous women maintained the IUD for contraception. There were two complete expulsions and three partial expulsions of the IUD, but there was no significant changes in menstruation and bleeding pattern, nor was infection or trauma observed. It was concluded that IUD insertion is a safe and effective method for emergency contraception for both parous and nulliparous women. One of the advantages of using an IUD is its long-term contraceptive effect, if the women prefer to continue its use.

MULTICENTER STUDY

(140)

The use of emergency contraception in Australasian emergency departments.

Emerg Med (Fremantle) 2001 Sep;13(3):314-8

Millar JR, Leach DS, Maclean AV, Kovacs GT.
Emergency Department, Box Hill Hospital, Melbourne, Victoria, Australia.

OBJECTIVE: To review the prescribing of emergency contraception by emergency departments in Australasia and compare it with other providers. **METHODS:** A postal questionnaire was sent to the director of each of the 79 Australasian College for Emergency Medicine accredited emergency departments in Australasia inquiring about the availability and prescribing habits for emergency contraception within each department. **RESULTS:** Of the 79 emergency departments, 69 (87.3%) responded to the questionnaire and were aware of the 'emergency contraception regimen'. The majority of departments prescribed appropriately (56%) and only one department did not arrange adequate follow up. Anti-emetics are always used by 45 departments (78.9%). Discussion of future contraceptive needs at the time of presentation was only undertaken by 25 departments (43.9%). Written clinical guidelines for emergency contraception were present in 28 departments (40.6%). **CONCLUSIONS:** Emergency departments are accessed by patients requesting contraception following unprotected intercourse or contraceptive failure. The prescribing of emergency contraception in Australasian emergency departments is comparable with other providers but substantial improvements could be made. Suggestions to assist this improvement include written clinical guidelines and patient information and purpose-made medication packs.

(141)

Modeling the cost and outcomes of pharmacist-prescribed emergency contraception.

Am J Public Health 2001 Sep;91(9):1443-5

Marciante KD, Gardner JS, Veenstra DL, Sullivan SD.
Department of Pharmacy, University of Washington, Seattle, 98195, USA. marciant@u.washington.edu

OBJECTIVES: This study investigated the effect on the risk and cost of unintended pregnancies of emergency contraceptive pills obtained directly from a pharmacist. **METHODS:** We used a decision model to compare outcomes for private and public payers following unprotected intercourse from. **RESULTS:** Obtaining emergency contraceptive pills from a pharmacy, compared with obtaining them from a physician or clinic, resulted in a \$158 (95% confidence interval (CI) = \$76, \$269) reduction in costs for private payers and a \$48 (95% CI = \$16, \$93) reduction for public payers. **CONCLUSIONS:** Our findings suggest that under varied assumptions, obtaining emergency contraceptive pills directly from a pharmacist reduces the number of unintended pregnancies and is cost saving.

(142)

Postcoital emergency contraception

Ther Umsch 2001 Sep;58(9):541-6

[Article in German]

Spycher C, Bigler G.

(Familienplanungs- und Beratungsstelle, Universitäts-Frauenklinik, Inselspital Bern.)

Abstract:

The actual methods of postcoital emergency contraception are described and compared. The method of choice is the administration of a progestagen-only pill because this method is more reliable and effective than the use of a combined estrogen-progestagen pill ("Yuzpe-Method"), and because the incidence of side-effects is considerably lower. The results obtained with levonorgestrel alone are presented by the authors. The postcoital introduction of a copper intrauterine device is highly effective, but invasive. This method is indicated if it is too late to use the pill. An open and accepting setting of the consultation and a way of taking the medical history that is pointing to the auto-responsibility are essential, especially for adolescents. Low conditions for the admission to the counselling are postulated, and the obligation to possess a medical prescription to obtain the only progestagen-only pill is questioned.

REVIEW; TUTORIAL

(143)

Community pharmacy supply of emergency contraception. Impact of emergency contraception on women's and men's behaviour requires further explanation.

BMJ 2001 Sep 29;323(7315):751

Bissell P, Anderson C, Bacon L, Taylor B, O'Brien K.

LETTER

(145)

Community pharmacy supply of emergency contraception. Collaboration is vital.

BMJ 2001 Sep 29;323(7315):752

Ward G.

LETTER

(146)

Mifepristone: a potential postcoital contraceptive.

Expert Opin Pharmacother 2001 Sep;2(9):1383-8

Ho PC.

(Department of Obstetrics and Gynaecology, University of Hong Kong. pcho@hkusub.hku.hk)

Abstract:

Mifepristone is an orally-active progesterone receptor antagonist. When a single dose of mifepristone is given in the mid- or late follicular phase, it may diminish or inhibit the luteinising hormone (LH) surge. In the early luteal phase, a single dose of mifepristone induces significant changes in the endometrium without affecting the hormonal levels or menstruation. When it is given in the mid-luteal phase, there will also be significant changes in the endometrium and some women may have two episodes of vaginal bleeding. A clinical trial suggests that a single dose of mifepristone in the early luteal phase may be an effective contraceptive agent but the lack of a cheap and easy method to identify the LH surge limits its clinical application. The administration of mifepristone alone or in combination with a prostaglandin does not appear to be an effective form of contraception. When used together with a prostaglandin, it may be an effective method for menstrual regulation but the cost and possible side effects of the prostaglandins limit its use. Mifepristone is a very effective method for emergency contraception. The incidence of side effects was also lower than that of the Yuzpe regimen. Lowering the dose of mifepristone from 600 to 10 mg does not decrease its efficacy but the incidence of delay in onset of the subsequent menses is reduced. Despite its efficacy, the reputation of mifepristone as an abortion pill may limit its access in many countries.

REVIEW; TUTORIAL

(147)

Emergency contraception: knowledge and attitudes of health care providers in a health maintenance organization.

Womens Health Issues 2001 Sep-Oct;11(5):448-57

Sherman CA, Harvey SM, Beckman LJ, Petitti DB.

(Oregon Center for Applied Science, Eugene, Oregon, USA.)

Abstract:

One hundred sixty-four health care providers in a health maintenance organization were surveyed in 1996 regarding their knowledge of, attitudes toward, and perception of barriers regarding emergency contraceptive pills (ECPs), as well as their ECP prescribing practices. Providers reported primarily positive attitudes regarding ECPs. Only 42% reported having ever prescribed ECPs; those who had prescribed had more positive attitudes about ECPs. Knowledge of ECP provision was incomplete, with 40% believing treatment had to be initiated in 48 hours or less. Barriers identified by providers included lack of a dedicated product, lack of awareness of ECPs among providers, and liability issues.

(148)

Emergency contraception: a matter of dedication and access.

CMAJ 2001 Oct 16;165(8):1095

Weir E.

NEWS

(149)

Emergency contraception: randomized comparison of advance provision and information only.

Obstet Gynecol 2001 Oct;98(4):570-5

Ellertson C, Ambardekar S, Hedley A, Coyaji K, Trussell J, Blanchard K.

(Population Council, Mexico City, Mexico. cellertson@popcouncil.org.mx)

OBJECTIVE: To determine whether multiple courses of emergency contraceptive therapy supplied in advance of need would tempt women using barrier methods to take risks with their more effective ongoing contraceptive methods. **METHODS:** We randomly assigned 411 condom users attending an urban family planning clinic in Pune, India, to receive either information about emergency contraception along with three courses of therapy to keep in case of need, or to receive only information, including that about the locations where they could obtain emergency contraception if needed. For up to 1 year, women returned quarterly for follow-up, answering questions about unprotected intercourse, emergency contraceptive use, pregnancies, sexually transmitted infections, and acceptability. **RESULTS:** Women given advance supplies reported unprotected intercourse at rates nearly identical to those among women given only information (0.012 versus 0.016 acts per month). Among those who did have unprotected intercourse, however, supply recipients were nearly twice as likely (79% versus 44%) to have taken emergency contraception, although numbers were too small to permit statistically significant inferences. No women used emergency contraception more than once during the study, even though everyone in the advance-supplies group had extra doses available. All women found knowing about emergency contraception useful, and all those receiving only information wished they had received supplies as well. **CONCLUSION:** Multiple emergency contraception doses supplied in advance did not tempt condom users to risk unprotected intercourse. After unprotected intercourse, however, those with pills on hand used them more often. Women found advance provision useful.

CLINICAL TRIAL; RANDOMIZED CONTROLLED TRIAL

(150)

On the mechanisms of action of short-term levonorgestrel administration in emergency contraception.

Contraception 2001 Oct;64(4):227-34

Durand M, del Carmen Cravioto M, Raymond EG, Duran-Sanchez O, De la Luz Cruz-Hinojosa M, Castell-Rodriguez A, Schiavon R, Larrea F.

(Department of Reproductive Biology, Instituto Nacional de Ciencias Medicas y Nutricion Salvador Zubiran, Mexico City, Mexico)

Abstract:

The effects of short-term administration of levonorgestrel (LNG) at different stages of the ovarian cycle on the pituitary-ovarian axis, corpus luteum function, and endometrium were investigated. Forty-five surgically sterilized women were studied during two menstrual cycles. In the second cycle, each woman received two doses of 0.75 mg LNG taken 12 h apart on day 10 of the cycle (Group A), at the time of serum luteinizing hormone (LH) surge (Group B), 48 h after positive detection of urinary LH (Group C), or late follicular phase (Group D). In both cycles, transvaginal ultrasound and serum LH were performed from the detection of urinary LH until ovulation. Serum estradiol (E(2)) and progesterone (P(4)) were measured during the complete luteal phase. In addition, an endometrial biopsy was taken at day LH + 9. Eighty percent of participants in Group A were anovulatory, the remaining (three participants) presented significant shortness of the luteal phase with notably lower luteal P(4) serum concentrations. In Groups B and C, no significant differences on either cycle length or luteal P(4) and E(2) serum concentrations were observed between the

untreated and treated cycles. Participants in Group D had normal cycle length but significantly lower luteal P(4) serum concentrations. Endometrial histology was normal in all ovulatory-treated cycles. It is suggested that interference of LNG with the mechanisms initiating the LH preovulatory surge depends on the stage of follicle development. Thus, anovulation results from disrupting the normal development and/or the hormonal activity of the growing follicle only when LNG is given preovulatory. In addition, peri- and post-ovulatory administration of LNG did not impair corpus luteum function or endometrial morphology.

(151)

The legal status of emergency contraception.

Int J Gynaecol Obstet 2001 Nov;75(2):185-91

Cook RJ, Dickens BM, Ngwena C, Plata MI.

(Faculty of Law, Faculty of Medicine and Joint Centre for Bioethics, University of Toronto, 84 Queen's Park, M5S 2C5, Toronto, Canada.)

Abstract:

Emergency contraception (EC), an intervention within 72 h of unprotected intercourse, dates back approximately 30 years, to the Yuzpe method. Recent development of a second generation of 'morning after,' better called 'emergency' contraceptives, has raised claims that they are abortifacient. These claims are largely rejected in medical, legal and much religious reasoning. Pregnancy is usually ascribed to the postimplantation period; means to prevent completion of implantation do not terminate pregnancy. An alternative attack on EC has arisen under South American laws that protect human life 'from conception.' The chance of conception from a single act of unprotected intercourse is very low, in view of limited times of fertility during menstrual cycles. The protection of a woman's life is not suspended during pregnancy. Risks to women's interests are more credible than the chance of conception having occurred. The claim to prohibit EC to protect embryonic life from conception is therefore problematic.

(152)

Adolescents' use of emergency contraception provided by Washington State pharmacists.

J Pediatr Adolesc Gynecol 2001 Nov;14(4):163-9

Sucato GS, Gardner JS, Koepsell TD.

(Departments of Pediatrics, University of Washington, Seattle, WA, USA)

Abstract:

Study Objective: To increase knowledge about adolescents who obtained emergency contraceptive pills (ECP) directly from a pharmacist without first contacting a physician. Design: Cross-sectional self-administered survey. Setting: Fifteen randomly selected pharmacies providing ECP in western Washington State. Participants: Adolescents 15-21 years old (n = 126) who obtained ECP directly from a pharmacist. Outcome Measures: Responses to a 20-item questionnaire examining adolescents' reasons for seeking care from a pharmacist, need for additional medical evaluation, risk for not receiving additional medical care, and satisfaction with care provided by the pharmacist. Results: The most common reasons for using the pharmacy were convenience (44%), lack of knowledge about alternatives (38%), and privacy (31%). If the pharmacy service were not available, 58% said they would see a doctor, 22% said they would wait to see if they got pregnant, and 20% did not know. Based on self-report, 81% of adolescents needed a new method of ongoing contraception, an evaluation for sexually transmitted disease, or both. Among these

adolescents, 36% had risk factors for not receiving this care. Adolescents were satisfied with the pharmacy service; 94% said they would recommend the service to a friend. Conclusions: ECP provision by pharmacists is a useful way to increase access to emergency contraception. However, many adolescents using ECP need additional medical care. Programs designed to increase ECP access should use these opportunities to link adolescents with more comprehensive reproductive health care services.

(153)

Should emergency contraception pills be available "over the counter"?

MCN Am J Matern Child Nurs 2001 Nov-Dec;26(6):294-5

Devine KS, Barron ML.

(Women's Health Nurse Practitioner, Fertility & Endocrine Associates, Louisville, KY, USA.)

(154)

Reproductive health services and the law and ethics of conscientious objection.

Med Law 2001;20(2):283-93

Dickens BM.

(Faculty of Law, Joint Centre for Bioethics, University of Toronto.)

Abstract:

Reproductive health services address contraception, sterilization and abortion, and new technologies such as gamete selection and manipulation, in vitro fertilization and surrogate motherhood. Artificial fertility control and medically assisted reproduction are opposed by conservative religions and philosophies, whose adherents may object to participation. Physicians' conscientious objection to non-lifesaving interventions in pregnancy have long been accepted. Nurses' claims are less recognized, allowing nonparticipation in abortions but not refusal of patient preparation and aftercare. Objections of others in health-related activities, such as serving meals to abortion patients and typing abortion referral letters, have been disallowed. Pharmacists may claim refusal rights over fulfilling prescriptions for emergency (post-coital) contraceptives and drugs for medical (i.e. non-surgical) abortion. This paper addresses limits to conscientious objection to participation in reproductive health services, and conditions to which rights of objection may be subject. Individuals have human rights to freedom of religious conscience, but institutions, as artificial legal persons, may not claim this right.

REVIEW; TUTORIAL

(155)

Emergency contraception.

Semin Reprod Med 2001;19(4):323-30

Ellertson C, Trussell J, Stewart F, Koenig J, Raymond EG, Shochet T.

(Director of Reproductive Health for Latin America and the Caribbean, The Population Council-Mexico, Col. Villa Coyoacan, Mexico.)

Abstract:

Emergency contraceptives are methods that prevent pregnancy when used shortly after unprotected sex. Three different emergency contraceptive methods are safe, simple, and widely available in the United States. These are: (1) ordinary combined oral contraceptives containing ethinyl estradiol and levonorgestrel taken in a higher dose for a short period of time and started within a few days after unprotected intercourse; (2) levonorgestrel-only tablets used similarly; and (3) copper-bearing intrauterine devices inserted within approximately 1 week after unprotected intercourse. Emergency contraceptive use is best known for women who have been raped, but the methods are also appropriate for women who have experienced condom breaks, women who did not use any method because they were not planning on having sex, or women who had unprotected intercourse for any other reason. Unfortunately, few women know about emergency contraceptives, and few clinicians think to inform their patients routinely about the option. A nationwide toll-free hotline (1-888-NOT-2-LATE) and a website (<http://not-2-late.com>) can help women learn about these options. Sharing "family planning's best-kept secret" widely with women could prevent as many as a million unwanted pregnancies annually in the United States.

(156)

Del mecanismo de acción de la administración a corto plazo de levonorgestrel como anticoncepción de emergencia (On the mechanism of action of short-term levonorgestrel administration in emergency contraception).

Contraception 2001; 64:227-34.

¹Durand M, ¹del Cravioto MC, ⁴Raymond EG, ¹Duran-Sanchez O, ¹De la Luz Cruz-Hinojosa M, ²Castell-Rodriguez A, ³Schiavon R, ¹Larrea F.

(¹Departamento de Biología de la Reproducción, Instituto de Ciencias Médicas y Nutrición salvador Zubirán; ²Departamento de Biología Celular, Escuela de Medicina, Universidad Autónoma de México; ³Servicio de Salud Reproductiva, Instituto Nacional de Pediatría. Ciudad de México, México. ⁴Family Health International, Research Triangle Park, NC, USA.)

Resumen: Se investigaron los efectos de la administración a corto plazo del levonorgestrel (LNG) sobre el eje hipofisis-ovario, la función del cuerpo lúteo y el endometrio en diferentes estados del ciclo menstrual. Se estudiaron 45 mujeres esterilizadas durante 2 ciclos menstruales. En el segundo ciclo, cada mujer recibió dos dosis de 0.75 mg de LNG separadas por 12 horas en el día 12 del ciclo (Grupo A), al momento de la elevación de la hormona luteinizante (LH) (Grupo B), 48 horas después de la detección de LH en orina (Grupo C) o en la etapa tardía (Grupo D). En ambos ciclos, se hizo ultrasonido vaginal y se midió LH en plasma desde que se detectó LH en orina hasta la ovulación. Se midió estradiol (E₂) y progesterona (P₄) durante toda la fase lútea. Además, se tomó una biopsia de endometrio en el día LH=9. Ochenta por ciento de las participantes en el Grupo A tuvieron ciclos anovulatorios, y las tres restantes tuvieron fases lúteas cortas con niveles significativamente más bajos de progesterona. En los grupos B y C, no hubo diferencias significativas en la duración del ciclo o en los niveles plasmáticos de P₄ y E₂ entre los ciclos tratados y los no tratados. Las participantes en el grupo D tuvieron una duración normal del ciclo pero niveles significativamente más bajos de P₄ en la fase lútea. La histología del endometrio fue normal en todos los ciclos ovulatorios tratados (n=24 biopsias). Se sugiere que la interferencia del LNG con los mecanismos que inician la descarga de LH preovulatoria depende del estado del desarrollo folicular. Así, la inhibición de la ovulación resulta de la alteración del desarrollo y/o la actividad hormonal del folículo solo cuando el LNG es dado preovulatorio. Además, la administración peri- o post-ovulatoria del LNG no alteró la función del cuerpo lúteo ni la morfología endometrial.

(157)

Emergency contraception provision: a survey of emergency department practitioners.

Acad Emerg Med 2002 Jan;9(1):69-74

Keshavarz R, Merchant RC, McGreal J.

(Department of Emergency Medicine, the Mount Sinai School of Medicine (RK, RCM, JM), New York, NY. Dr. Merchant is currently in the Section of Emergency Medicine, Brown University School of Medicine, Providence, RI.)

OBJECTIVES: To determine emergency department (ED) practitioner willingness to offer emergency contraception (EC) following sexual assault and consensual sex, and to compare responses of practitioners from states whose laws permit the refusal, discussion, counseling, and referral of patients for abortions (often called "opt-out" or "abortion-related conscience clauses") with those of practitioners from states without these laws. **METHODS:** Using a structured questionnaire, a convenience sample of ED practitioners attending a national emergency medicine meeting was surveyed. **RESULTS:** The 600 respondents were: 71% male, 29% female; 34% academic, 26% community, and 33% resident physicians; and 7% nurse practitioners and physician assistants. Many respondents (88%) were inclined to offer EC to those sexually assaulted by unknown assailants. More practitioners said they were willing to offer EC if the assailant was known to be HIV-infected rather than if the assailant had low HIV risk factors (90% vs. 79%, $p < 0.01$). More respondents would prescribe EC after sexual assault than consensual sex (88% vs. 73%, $p < 0.01$). The rates of willingness to offer EC were the same for practitioners in states with "abortion-related conscience clauses" and those from other states. **CONCLUSIONS:** Most ED practitioners said they were willing to offer EC. Although the risk of pregnancy exists after consensual sex, practitioners were less willing to prescribe EC after those exposures than for sexual assault. "Abortion-related conscience clauses" did not seem to influence willingness to offer EC.

(158)

Anticoncepción de emergencia con mifepristona y levonorgestrel: mecanismo de acción (Emergency contraception with mifepristone and levonorgestrel: mechanism of action).

Obstet Gynecol 2002;100:65-71.

Marions L, Hultenby K, Lindell I, Sun X, Stabi B, Gemzell Danielsson K.
Department of Women and Child Health, Karolinska Hospital and Unit of , Huddinge Hospital, Stockholm, Sweden.

Objetivo: Estudiar el efecto de mifepristona y levonorgestrel en dosis efectivas como anticoncepción de emergencia en la función ovárica y el desarrollo del endometrio.

Métodos: Doce mujeres fértiles se trataron con 10 mg de mifepristona en dosis única ($n=6$) o con dos dosis de 0.75 mg de levonorgestrel, separadas por 12 horas ($n=6$), antes o después de la ovulación. Se hizo una biopsia de endometrio en el período de receptividad endometrial, la que se analizó para maduración endometrial y marcadores de receptividad endometrial. Se analizaron 8 parámetros morfométricos al microscopio de luz y uno morfológico al microscopio electrónico de barrido. Los marcadores examinados fueron integrina $\alpha 4$ y $\beta 3$, ciclooxigenasa -1 y -2, receptores de progesterona, aglutinina *Dolichos biflorus* ligante de lectina y pinopodos. Se determinó además la excreción urinaria de hormona luteinizante, estrona y pregnandiól.

Resultados: El tratamiento con mifepristona y levonorgestrel antes de la ovulación inhibió la descarga de hormona luteinizante. Cuando se administró mifepristona en la fase lútea temprana, se suprimió la regulación inhibitoria de receptores de progesterona en 5 de 6 mujeres. No se encontraron otras alteraciones significativas de ninguno de los marcadores de receptividad endometrial. En las mujeres tratadas con levonorgestrel, ninguno de los parámetros examinados mostró diferencias con lo observado en las biopsias obtenidas en los ciclos controles de las mismas mujeres.

Conclusión: El mecanismo de acción de la anticoncepción de emergencia con mifepristona o levonorgestrel es primariamente la inhibición de la ovulación y no la inhibición de la implantación.

(159)

Effects of the Yuzpe regimen, given during the follicular phase, upon ovarian function

Contraception 2002;65:121-8

Croxatto HB, Fuentealba B, Brache V, Salvatierra AM, Alvarez F, Massai R, Cochon L, Faúndes A.

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Jounal AIDS Care, n.14(6), 2002, p. 779-788.

Civic, D.

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Rev. Saúde Pública vol.36 nº. 4 suppl. São Paulo, Ago. 2002.

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I Conferência Latinoamericana de Anticoncepción de Emergencia, CLAE, Equador, 2002

Drezzett, J.

Artigo: <http://www.ipas.org.br/arquivos/jefferson/CLAE.doc>

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Advanced Supply of Emergency Contraception for Adolescent Mothers Increased Utilization without Reducing Condom or Primary Contraception Use

Journal of Adolescent Health , n. 32(2), 2003. p.122-123.

Belzer, M. & cols.

Matéria Aids Portugal: <http://www.aidsportugal.com/print.php?sid=2563>

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The Benefits and risks of over-the-counter availability of levonorgestrel emergency contraception.

Contraception, n. 69, 2003. p. 309-317.

Camp, S.L.; Raine, T.R, Wilkerson, D.S.

Abstract: "[The benefits and risks of over-the-counter availability of levonorgestrel emergency contraception](#)"

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El tratamiento postcoital con levonorgestrel no altera los eventos postfecundación en la rata (Postcoital treatment with levonorgestrel does not disrupt postfertilization events in the rat).

Contraception 2003, 67:415-419.

Muller AL, Lladós C, Croxatto HB.

(Pontificia Universidad Católica de Chile, Facultad de Ciencias Biológicas, Unidad de Reproducción y Desarrollo, Santiago, Chile)

Resumen: El levonorgestrel (LNG), una progestina ampliamente usada para anticoncepción hormonal regular, también es usada en anticoncepción de emergencia (AE) para prevenir el embarazo después de un coito no protegido. Sin embargo, su modo de acción en AE sólo se entiende parcialmente. Una pregunta no resuelta es si AE previene el embarazo interfiriendo con eventos postfecundación. Aquí, nosotros reportamos los efectos del tratamiento agudo con LNG sobre la ovulación, fecundación e implantación en la rata. LNG inhibió la ovulación total o parcialmente, dependiendo del momento del tratamiento y/o la dosis total administrada, mientras que no tuvo efecto en la fecundación ni la implantación cuando se administró justo antes o después del coito, o antes de la implantación. Se concluyó que la administración postcoital aguda de LNG, a dosis varias veces mayor que la usada para AE en mujeres, que es capaz de inhibir la ovulación, no tenía ningún efecto post-fecundación que haga disminuir la fertilidad en la rata.

(167)

Efecto de la Administración de Levonorgestrel Solo como Anticoncepción de Emergencia (AE) sobre la Función Ovulatoria

Resúmenes de la XVIII Reunión de la Asociación Latinoamericana de Investigadores en Reproducción Humana. Varadero, Cuba 28-31 Mayo, 2003

Brache V¹, Croxatto H², Cochon L¹, Massai R², Alvarez F¹, Forcelledo ML², Faundes A¹., Pavez M² Salvatierra AM²

(¹ PROFAMILIA, Santo Domingo, Republica Dominicana ² ICMER, Santiago, Chile.)

Objetivo: Evaluar el efecto del LNG solo (0.75 mg, repetido a las 12 horas) como AE sobre el desarrollo folicular y la función ovulatoria, al ser administrado en tres distintos periodos de la fase folicular, basados en diámetro folicular (DF).

Material y Métodos: Participaron 57 voluntarias, asignadas aleatoriamente a uno de tres grupos: Grupo 1 DF entre 12-14 mm; 2: DF entre 15-17 mm y 3: DF entre -18 mm. Cada voluntaria participó en un ciclo de tratamiento y uno placebo. Se realizaron ecografías interdiarias iniciando el día 8 del ciclo hasta alcanzar el DF asignado. Se midieron LH, FSH, estradiol (E2) y progesterona (P) séricos y el DF máximo, el día del tratamiento (antes de la administración) y por 5 días consecutivos (periodo máximo de viabilidad de los espermios, si hubiera ocurrido coito pre-tratamiento), seguido por 2 veces por semana hasta la menstruación siguiente.

Resultados: La tabla muestra el % de ciclos en los cuales se observó inhibición de la rotura folicular (RF) en los 5 días siguientes al tratamiento o disfunción ovulatoria (ciclos con pico de LH parcial o totalmente suprimido).

DF	Inhibición Rotura Folicular		Disfunción Ovulatoria		Inhibición RF + Disf. Ovul.	
	LNG	Placebo LNG	Placebo	LNG	Placebo	
12-14 mm	15/18(83%)	10/18(56%)	2/18(11%)	1/18(6%)	17/18(94%)	11/18(61%)
15-17 mm	8/22(36%)	8/22(36%)	12/22(54%)	2/22(9%)	20/22(91%)	10/22 (46%)
-18 mm	2/17(2%)	2/16(12%)	6/17(35%)	0/16(0%)	8/17(47%)	2/16(12%)

No hubo diferencias significativas en el porcentaje de inhibición de la rotura folicular entre tratadas y placebo, pero hubo diferencias en el porcentaje de ciclos con disfunción ovulatoria. Los niveles de LH (Día -1 RF: 7.5 ± 3.3 vs. 47.6 ± 26 , $x \pm DS$) y E2 (Día -1 RF: 440 ± 152 vs. 607 ± 320 , $x \pm DS$) desde tratamiento hasta la rotura folicular en las mujeres tratadas con LNG fue significativamente menor que las que recibieron placebo. Mientras antes se administra el tratamiento en relación con el desarrollo folicular, mayor es el efecto sobre la disfunción ovulatoria o inhibición de rotura folicular.

Conclusiones: La administración de LNG cuando el foliculo dominante mide hasta 17 mm causa inhibición de la rotura folicular o disfunción ovulatoria en mas de 90% de los casos y en un poco menos de la mitad de las tratadas con DF - 18mm. Este mecanismo de acción puede ser responsable de la prevención de embarazos asociados a este método.

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Efecto de Levonorgestrel como Anticoncepción de Emergencia sobre Receptores de Endometrio durante la Ventana de Implantación.

Resúmenes de la XVIII Reunión de la Asociación Latinoamericana de Investigadores en Reproducción Humana. Varadero, Cuba 28-31 Mayo / 2003.

Palomino A, Boric A, Gabler F, Espinoza A, Vega M, Devoto L.
(Instituto de Investigaciones Materno Infantil, Departamento Obstetricia y Ginecología, Facultad de Medicina, Hospital Clínico San Borja- Ariarán. Santiago, Chile)

Objetivo: Evaluar el efecto de LNG (1.5 mg dosis única) sobre la expresión del receptor de progesterona (RP) en el epitelio endometrial y las características clínicas del ciclo menstrual.

Metodología: Se administró LNG 1.5 mg por vía oral a mujeres voluntarias previamente esterilizadas por salpingoligadura; las cuales aceptaron y firmaron un consentimiento informado, aceptado por el Comité de

Etica del HCSBA. El grupo control estuvo representado por mujeres de las mismas características de los casos. Se administró LNG o placebo el día del alza de LH en orina y con folículo preovulatorio (17-18 mm) determinado por seguimiento folicular ecográfico transvaginal. La expresión y localización de RP fueron determinadas por inmunohistoquímica, en biopsias de endometrio obtenidas 7-8 días después del alza de LH en orina. La evaluación histológica se realizó según los criterios clásicos de Noyes. Los resultados se compararon utilizando la prueba estadística student t con significancia $p < 0.05$.

Resultados: La comparación de las características clínicas y endocrinas de los grupos no fue diferente $p > 0.05$. La concentración plasmática de progesterona fue de 9.4 ± 2.4 y 8.7 ± 2.4 en los casos y controles respectivamente. El RP no se expresa en el epitelio glandular y la localización e intensidad de la tinción en estroma fue similar en ambos grupos. La evaluación histológica de las biopsias de endometrio tanto de casos como controles fueron observados "en fase" exhibiendo características consistentes con día 21-23 del ciclo.

Conclusiones: Los datos del presente estudio indican que, en condiciones en que la administración de LNG no altera el proceso ovulatorio, no impide la síntesis de progesterona por el cuerpo lúteo. El LNG no modifica el patrón de expresión de los receptores de progesterona. En conjunto, estos datos no muestran modificaciones en la morfología del endometrio y la expresión de RP durante la ventana de implantación.

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La administración post-coital de levonorgestrel no interfiere con eventos post-fecundación en la mona del nuevo mundo *Cebus apella* (Post-coital administration of levonorgestrel does not interfere with post-fertilization events in the new-world monkey *Cebus apella*). *

Human Reproduction (enviado en Noviembre, 2003)

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Antecedentes: No se ha publicado previamente ninguna evidencia experimental directa que confirme o excluya que el levonorgestrel (LNG) administrado como anticoncepción de emergencia (AE) prevenga el embarazo en la mujer interfiriendo con procesos reproductivos que ocurren después de la fecundación. Aquí determinamos el efecto de la administración post-coital y pre-ovulatoria de levonorgestrel (LNG) en la fertilidad y en la ovulación, respectivamente, en monas *Cebus*. Determinamos el efecto del LNG en la fertilidad cuando la administración se hizo alrededor de la ovulación y sobre la ovulación cuando se administró en la fase folicular temprana o tardía.

Métodos: En el primer experimento, se administró LNG 0.75 mg o vehículo una o dos veces por vía oral o subcutánea dentro de las primeras 24 h después del coito, el que ocurrió muy cerca de la ovulación. En las hembras que se embarazaron se indujo un aborto con mifepristona y re-ingresaron al estudio después de un ciclo de descanso, hasta que cada una de las 12 hembras contribuyeran, de modo randomizado, con 2 ciclos tratados con LNG y con 2 ciclos tratados con vehículo. En un segundo experimento, se inyectó dos veces LNG 0.75mg o vehículo, en la fase folicular, coincidiendo con folículos menores o mayores de 5 mm de diámetro. Seis hembras contribuyeron con ciclos 5 tratados cada una.

Resultados: La tasa de embarazos fue idéntica en los ciclos tratados con vehículo y LNG. El LNG inhibió o retrasó la ovulación sólo cuando el tratamiento coincidió con un folículo < 5 mm diámetro.

Conclusión: En la mona *Cebus*, el LNG puede inhibir o retrasar la ovulación pero, cuando la fecundación se ha producido, no puede prevenir que se establezca el embarazo. Estos hallazgos no apoyan la hipótesis de que el LNG post-coital prevenga el embarazo interfiriendo con eventos que ocurren después de la fecundación.

* Este trabajo recibió el Premio Anual 2003 de la Sociedad Chilena de Fertilidad y Esterilidad.

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Knowledge of emergency contraception among women aged 18 to 44 in California

American Journal of Obstetrics and Gynecology , 2004.

Foster, D; Harper.C.

Abstract: "[Knowledge of emergency contraception among women aged 18 to 44 in California](#)"

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Tolerability of levonorgestrel emergency contraception in adolescents

American Journal of Obstetrics and Gynecology (2004)

Harper, C; Rocca; C. Darney, P; Cynthia Harper; von Hertzen, H; Raine, T

Abstract: "[Tolerability of levonorgestrel emergency contraception in adolescents](#)"

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The Role of Emergency Contraception

American Journal of Obstetrics and Gynecology, 2004

James Trussell, PhD, Charlotte Ellertson, PhD, Felicia Stewart, MD,

Abstract: "[The Role of Emergency Contraception](#)"

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Contraceção de Emergência no Brasil: necessidade, acesso e política nacional

Revista Eletrônica de Saúde Sexual e Reprodutiva, IPAS-Brasil, Setembro de 2004.

Figueiredo R

Disponível em <http://ipas.org.br/revista/set04.html#dois>

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La anticoncepción de emergencia en América Latina y el Caribe

Revista Panamericana de Salud Pública, Vol. 16, No.6, 2004.pp.424-431.

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Direct Access to Emergency Contraception Through Pharmacies and Effect on Unintended Pregnancy and STIs – a randomized controlled trial.

Journal of the American Medical Association, n. 293, 2005. p.54-62.

Raine, T. & cols.

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Effects of making emergency contraception available without a physician's prescription: a population-based study

CMAJ • MAR. 29, 2005; 172 (7)

Soon J, Levine M, Osmond B, Ensom M, Fielding D

Abstract: [prescri.pdf](#)

In an attempt to minimize these problems, the frameless intrauterine implant (IUI) was developed. Clinical studies conducted over the past 12 years have shown the validity of the anchoring concept. The design characteristics of the IUI (fixed, frameless and flexible) are responsible for the low expulsion, high effectiveness and high tolerance rates.Â This article reviews the clinical experience with the GyneFix intrauterine implant system for interval, emergency and post-abortal contraception. The relatively high rate of unintended pregnancies and abortions in the world signifies that greater access to contraception is necessary.