CLINICAL

EMERGENCY CONTRACEPTION

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INTRODUCTION

Because emergency contraception (EC) was previously termed the “morning after pill”, many people interpreted that literally and delayed taking emergency contraceptives until the next morning, thus missing an opportunity to use the method properly.

The rate of unsafe abortion per 100 live births is 14% in Africa, 14% in Asia, 7% in Europe and 32% in Latin America and the Caribbean (WHO 2004). More extensive use of EC could save considerable medical and social costs by reducing unintended pregnancies, which are expensive.

Requests for EC come from two main groups. The first group is already using contraception but has a problem such as condom failure or missed contraceptive pills. The second group does not use contraception because they are not expecting to have sex. It is therefore evident that there must be a system in place to provide a comprehensive post-coital service for all of those people who require it.

EMERGENCY CONTRACEPTIVE REGIMENS

Progestins
Contraceptive actions of progestins occur in four ways:

- They affect ovulation in a dose dependent manner. This occurs by suppressing the mid-cycle peak of luteinising hormone and follicle stimulating hormone. As in combined contraceptives, it is the progestin component which provides the contraceptive effect; oestrogen is added only to guarantee a better bleeding regularity.

- Progestins cause the production of a thick cervical mucous plug, which prevents the penetration of sperm into the endometrial cavity.

- Progestins transform the endometrium, making it unsuitable for nidation by inhibiting the synthesis of progesterone receptors, thereby increasing the stromal tissue and decreasing the number of glands and stromal oedema.

- Progestins may reduce tubal motility and cilia action.

Progestogen-only contraceptives have
EMERGENCY CONTRACEPTION IN PATIENTS WITH LIFE-THREATENING MEDICAL CONDITIONS

Patients with angina, migraine, liver disease, venous and arterial thrombotic diseases, cerebro-vascular incidents etc., should be offered emergency contraception as the clinical impact of a single dose or a dual dose of progestogen-only or mifepristone, is little.\(^7\)

The World Health Organisation categorises all these medical conditions as category B, which means that the benefits of using emergency contraceptives in these conditions, generally outweigh the theoretical or proven risks.\(^10\)

CONCLUSION

There are no absolute contraindications to the use of emergency contraceptives. Clinicians are advised to offer a single dose of 1.5 mg levonorgestrel or a single dose of 10 mg mifepristone at the time of presentation. Those patients who request prolonged contraception should be offered the copper containing intra-uterine contraceptive device if there are no contraindications to its use. The yuzpe regimen as a first line method is not recommended.

The WHO working group on contraceptives suggests that a patient be given an advance supply of emergency contraceptives to ensure that she will have them available when needed and can take them as soon as possible after unprotected intercourse.\(^\)