CLINICAL GUIDELINE

Emergency Contraception

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	2
Does this version include changes to clinical advice:	Yes
Date Approved:	10th March 2026
Date of Next Review:	30th September 2026
Lead Author:	Kay McAllister
Approval Group:	Sandyford Governance Group
Guideline ID number:	1264

Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

West of Scotland Sexual Health Managed Clinical Network

NHS Ayrshire & Arran | NHS Dumfries & Galloway | NHS Forth Valley | NHS Greater Glasgow and Clyde | NHS Lanarkshire

Adapted from West of Scotland Protocol ***Sandyford Guidelines***

EMERGENCY CONTRACEPTION

What's New:
No interruption of breastfeeding is necessary following a single dose of Ulipristal Acetate when given for Emergency Contraception.

Decision Making Tool – see Algorithm 1 in Appendix

Offer all clients Cu-IUD as 1st line choice

If client declines Cu-IUD or it is unsuitable, prescribe UPA-EC unless contraindicated or quick starting**

When UPA-EC contraindicated or quick starting prescribe LNG-EC

If prescribing UPA-EC or LNG-EC check BMI and weight as the dose and choice may need to be adjusted (see relevant section in protocol)

*Contraindications to UPA-EC:

- Asthma controlled by oral glucocorticoids

**In some circumstances where the benefits of immediate quick start of hormonal contraception potentially outweigh the risk or pregnancy from unprotected sex which has already taken place, LNG-EC and 'quick starting' a hormonal method is preferred over UPA-EC.

If weight > 70 kg or BMI > 26 Cu-IUD remains the 1st choice. If not acceptable, offer UPA-EC. If not appropriate offer double dose LNG-EC.

Indications For Use

EC is appropriate for women who do not wish to conceive following:

- Unprotected sexual intercourse (UPSI)
- Failure or potential failure of a contraceptive method (see Table 1 in Appendix)
- UPSI following Day 21 after childbirth (unless the criteria for lactational amenorrhoea are met)
- UPSI from Day 5 after abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease (GTD)

Mode of action/efficacy of available methods

- **Copper Intrauterine device (Cu-IUD)**
  - Inhibition of fertilisation by its toxic effect on sperm and ova. Adversely affects the motility and viability of sperm and the viability and transport of ova.
  - If fertilisation does occur, the local endometrial inflammatory reaction prevents implantation.
  - Can be Inserted up to:
    - 5 days following first UPSI since LMP
      OR

5 days after the earliest likely ovulation date
  - This is the most effective method of EC. Failure rate <0.1%

- **Ullipristal Acetate (UPA-EC) (30mg)**
  - Selective progesterone receptor modulator.
  - Acts by delaying ovulation for at least 5 days, until sperm from the UPSI for which EC was taken are no longer viable.
  - It delays ovulation even after the start of the luteinising hormone (LH) surge whereas LNG-EC is no longer effective after the start of the LH surge.
  - Not effective after ovulation.
  - after UPA-EC, the majority of women will go on to ovulate later in the cycle and are therefore at risk of pregnancy from subsequent UPSI.
  - It is essential that women are made aware of this risk and advised regarding ongoing contraception.
    Efficacy is dependent on timing of UPSI in relation to ovulation.
    The overall pregnancy rate after administration of UPA-EC is about 1-2%.
  - Efficacy may be reduced in women with BMI greater than 30m2 or weight greater than 85kg. Double dose UPA –EC is not currently recommended.

- **Levonorgestrel (LNG-EC) (1.5mg)**
  - Inhibits ovulation, delaying or preventing follicular rupture and causing luteal dysfunction.
  - Needs to be taken prior to the start of the luteal hormone (LH) surge, LNG inhibits ovulation for the next 5 days, until sperm from the UPSI for which it was taken are no longer viable.
  - UPA-EC can delay ovulation even after the start of LH surge.
  - After taking LNG-EC, women who ovulate later in the cycle are at risk of pregnancy from further UPSI. It is essential that women are made aware of this risk and advised regarding ongoing contraception.
    Efficacy is dependent on timing of UPSI in relation to ovulation.
    LNG-EC within 72 hours of a single episode of UPSI is thought to be 85%.
  - Women weighing greater than 70kg or BMI greater than 26, offer double dose (3mg) LNG-EC, if copper coil and UPA-EC are not appropriate.

<u>Client Assessment and Management</u>

The risk of pregnancy after UPSI depends on a number of variable factors including the fertility of both partners, the timing and number of episodes of UPSI, cycle length and variability, and whether contraception has not been used or has been used incorrectly.
See individual sections below. For further information, please refer to the FSRH CEU Guideline on Emergency Contraception.

1. Establish whether sex was consensual. If not, see “Sexual Assault” protocol
2. If the client is under 16 years, complete the local Young Peoples proforma
3. Obtain a sexual history and offer testing for sexually transmitted infections (STI) if appropriate
4. Obtain a medical and drug history to exclude contra-indications to EC
5. If oral EC is chosen, check weight and BMI
6. Offer EC based on Algorithms 1 in the Appendix
7. Discuss future contraception, quick starting contraception and safer sex/infection risks
8. Arrange future appointments for STI testing, pregnancy testing and ongoing contraception as appropriate following the consultation.

9. Record consultation notes and any prescriptions on NaSH

1. **Sexual Assault**
   - If a woman opts for forensic examination and chooses Cu-IUD as EC, clinical examination and insertion should be deferred until after this examination. Antibiotic cover needs to be considered.
   - If a woman elects to have a **Cu-IUD** as EC, **prescribe oral EC** in case **Cu-IUD fitting is delayed or she changes her mind**.
   - Please ensure that the client is offered EC/STI testing if her care is transferred to Forensic Medical Examiners.

2. **Young Peoples Proforma**
   - Please follow local guidance for this form. Some units inform the Young People (YP) Team of all attendances < 16 yrs.
   - Complete a Young Peoples Risk Assessment on NaSH
   - All methods of EC, including Cu-IUD, should be offered to adolescent women.

3. **Sexually transmitted Infection (STI) Testing**
   - STI risk assessment should be made and testing offered as appropriate, taking window periods into consideration.
   - Antibiotic cover may be considered for Cu-IUD insertion if there is a significant risk of STI that could be associated with ascending pelvic infection.

4. **Medical and Drug History**

   - <u>Enzyme Inducers</u>
     - The effectiveness of oral EC may be reduced in those taking drugs which are enzyme inducers and Cu-IUD should be recommended to these women.
     - If oral EC is chosen, 3mg LNG should be considered, but the woman should be informed that the effectiveness of this regimen is unknown. There is no evidence to support an increased dose of UPA-EC.

   - <u>Progestogen-containing drugs</u>
     - Effectiveness of UPA-EC could theoretically be reduced if any progestogen-containing drug has been taken in the 7 days prior to EC use.
     - The increased efficacy of UPA over LNG must be balanced against the theoretical reduced efficacy of prior progestogen, taking into consideration any quick starting plans. Please see the Quick Starting protocol. An exception to this is in ESTABLISHED CHC users who have missed pills (or patch/ring removal) in days 2-7 of week 1 after hormone-free week. They can restart the method immediately after UPA-EC and use additional precautions for next 7 days (9 if Qlaira) All products containing a progestogen or progesterone should be avoided in the 5 days after taking UPA-EC.
     - UPA-EC is not suitable for any woman with asthma controlled by oral glucocorticoids.

   - <u>Breast feeding</u>
     There is a higher rate of uterine perforation during Cu-IUD insertion in breastfeeding women.

- There is no need to interrupt breast-feeding after a single dose of ullipristalLNG-EC has not been shown to affect breast milk.

- Previous EC use in cycle
  - If already taken UPA-EC once or more in a cycle, can offer UPA-EC again after further UPSI in the same cycle.
  - If already taken LNG-EC once or more in a cycle, can offer LNG-EC again after further UPSI in the same cycle.
  - If a woman has already taken UPA-EC, LNG-EC should not be taken in the following 5 days.
  - If a woman has already taken LNG-EC, UPA-EC could theoretically be less effective if taken in the following 7 days.

5. Weight and BMI

If weight >70 kg or BMI >26 Cu-IUD remains the 1st choice. If not acceptable, offer UPA-EC. If not appropriate offer double dose LNG-EC.

6. Decision-making algorithms

These aid the decision to which method of EC is the most appropriate. However, the final choice must take into consideration client choice and whether there is also quick-starting of an ongoing contraceptive method. See Algorithm 1Algorithm in Appendix.

a. Cu-IUD EC

- The most effective method and the ONLY one effective after ovulation.
- Contraindications are the same as for any routine Cu-IUD insertion.
- Provides ongoing contraception.

b. UPA-EC

- Has been shown to be effective up to 120 hours after UPSI and more effective than LNG-EC at ALL times.
- Can be given more than once in a cycle. If UPA-EC has already been given in the cycle, LNG-EC should not be given in the following 5 days.
- If UPSI has occurred in the 5 days prior to ovulation, this should be the first line oral EC if a Cu-IUD has been declined.
- Women must wait 5 days after UPA-EC before starting ongoing hormonal contraception. Exception to this is established CHC users who commenced method correctly on day 1 after hormone free week and had pill failure (or similar patch or ring failure) on days 2-7 of week 1 only. The method can be restarted immediately then use condoms for 7 days (9 for Qlaira)
- During this period condoms or abstinence must be used reliably. See quick-start protocol for more information.

c. LNG-EC

- Licensed for up to 72 hours following UPSI. Evidence suggests it is ineffective after 96 hours.
- Can be given more than once in a cycle, but if further EC is required there is a theoretical reduced effectiveness of UPA-EC if given in the following 7 days.
- Hormonal contraception can be started immediately after LNG-EC, making this the more suitable oral EC if there is likely to be further UPSI in the cycle due to a delay in commencing an ongoing method. See Quick Start Protocol for more

information.

7. Discuss future contraception, quick starting contraception and safer sex/infection risks.

8. Arrange future appointments for STI testing, pregnancy testing and ongoing contraception as appropriate following the consultation.
   - Advise women that if they vomit within 3 hours of taking oral EC, they should return for a repeat prescription.
   - Advice women to take a pregnancy test 21 days following last UPSI to assess their pregnancy status.

9. Record consultation notes and any prescriptions on NaSH, including whether EC was off license.

References

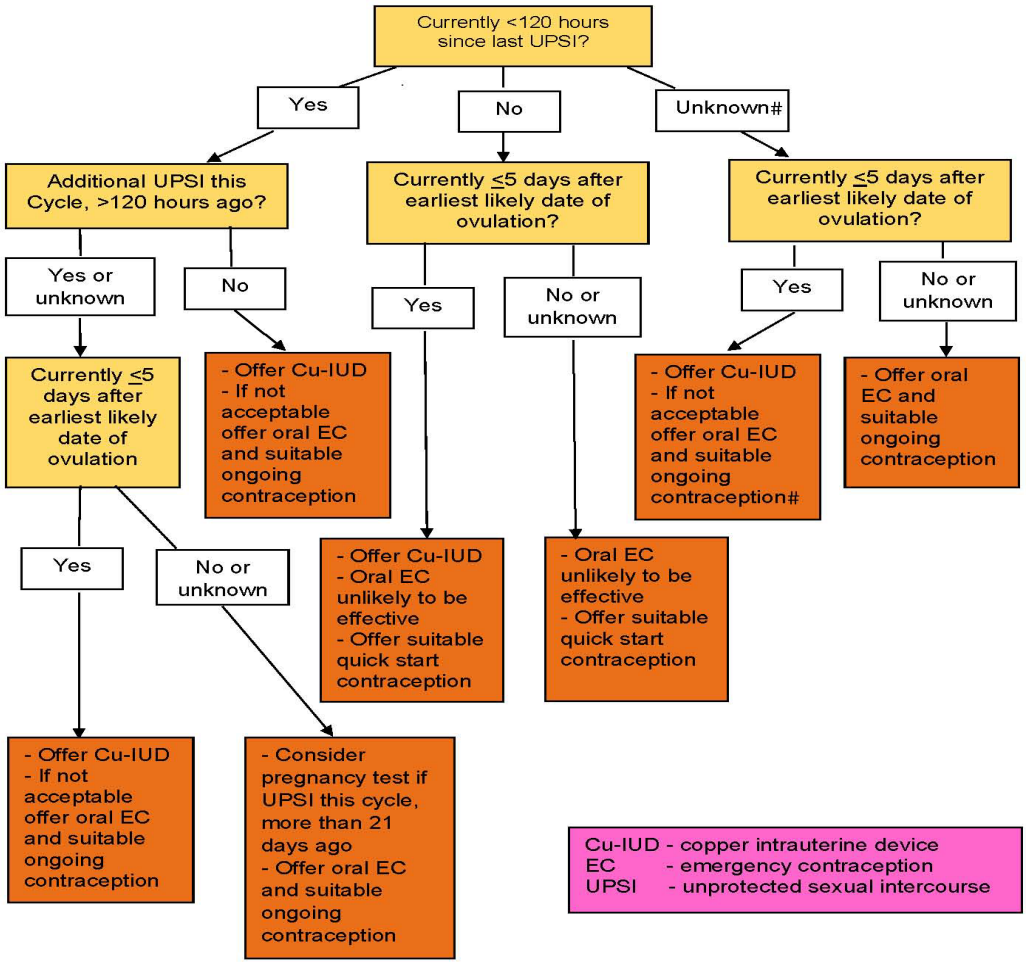
1. FSRH CEU Guideline Emergency Contraception. March 2017 (Ameded July 2023). Available from: www.fsrh.org/standards-and-guidance/current-clinical-guidance/emergency-contraception/ (accesses 7.3.25)
2. FSRH-Statement-Ulipristal-Acetate-and-Breastfeeding.pdf (accessed 7.3.25)

Appendix

Table 1: Indications for emergency contraception following potential failure of hormonal and intrauterine methods of contraception (FSRH CEU EC Guideline)

Method	Situation leading to possible contraceptive failure	Indication for EC
Hormonal methods of contraception	Failure to use additional contraceptive precautions when starting the method	UPSI or barrier failure during time that additional precautions required as indicated within CEU guidance.
Combined hormonal transdermal patch or combined hormonal vaginal ring	Patch detachment/ring removal for >48 hours Extension of patch-free or ring-free interval by >48 hours	EC is indicated if patch detachment or ring removal occurs in Week 1 and there has been UPSI or barrier failure during the hormone-free interval (HFI) or Week 1. If the HFI is extended, a Cu-IUD can be offered up to 13 days after the start of the HFI assuming previous perfect use. If CHC has been used in the 7 days prior to EC, the effectiveness of UPA-EC could theoretically be reduced. Consider use of LNG-EC.
Combined oral contraceptive pill (monophasic pill containing ethinylestradiol)	Missed pills (if two or more active pills are missed)	EC is indicated if the pills are missed in Week 1 and there has been UPSI or barrier failure during the pill-free interval or Week 1. If the pill-free interval is extended (this includes missing pills in Week 1), a Cu-IUD can be offered up to 13 days after the start of the HFI assuming previous perfect use. If COC has been taken in the 7 days prior to EC, the effectiveness of UPA-EC could theoretically be reduced. Consider use of LNG-EC.
Combined hormonal contraception, progestogen-only pill and progestogen-only implant	Failure to use additional contraceptive precautions whilst using liver enzyme inducing drugs or in the 28 days after use	EC is indicated if there is UPSI or barrier failure during, or in the 28 days following, use of liver enzyme-inducing drugs. Offer a Cu-IUD (unaffected by liver enzyme-inducing drugs) or a double dose (3 mg) of LNG-EC. UPA-EC is not recommended with liver enzyme-inducing drugs.
Progestogen-only pill	Late or missed pill (>27 hours since last traditional POP or >36 hours since last desogestrel-only pill)	EC is indicated if a pill is late or missed and there has been UPSI or barrier failure before efficacy has been re-established (i.e. 48 hours after restarting).

		Timing of ovulation after missed pills cannot be accurately predicted. A Cu-IUD is therefore only recommended up to 5 days after the first UPSI following a missed POP. If POP has been taken in the 7 days prior to EC, the effectiveness of UPA-EC could theoretically be reduced. Consider use of LNG-EC.
Progestogen-only injectable		EC is indicated if there has been UPSI or barrier failure: • >14 weeks after the last injection • within the first 7 days after late injection Timing of ovulation after expiry of the progestogen only injectable is extremely variable. A Cu-IUD is only recommended up to 5 days after the first UPSI that takes place >14 weeks after the last DMPA injection. The effectiveness of UPA-EC could theoretically be reduced by residual circulating progestogen. Consider use of LNG-EC.
Progestogen-only implant	Expired implant	Low risk of pregnancy in 4th year PO-Implant. Effectiveness of UPA-EC unknown. See FSRH CEU EC Guideline.
Intrauterine contraception (Cu-IUD and LNGIUS)	Removal without immediate replacement; partial or complete expulsion; threads missing and IUC location unknown	If UPSI has occurred in the 7 days (the duration of sperm viability in the upper genital tract) prior to removal, perforation, partial or complete expulsion. Depending on the timing of UPSI and time since IUD known to be correctly placed, it may be appropriate to fit another Cu-IUD for EC. If missing LNG-IUS threads and unable to confirm placement with a scan, consider LNG-EC due to reduction in effectiveness of UPA-EC due to progestogens.

Adapted from West of Scotland Protocol ***Sandyford Guidelines***

Algorithm 1: Decision-making Algorithm for Emergency Contraception (EC): Copper Intrauterine Device (Cu-IUD) vs Oral EC[1]