CMSHN Draft Protocol **September 2012**

QUICK STARTING CONTRACEPTION

Quick starting refers to the commencement of contraception at the time a woman presents, rather than waiting for her next menstrual cycle. This practice may be outside the product license / device instruction of the chosen method, but may have potential benefits such as reducing the time she is at risk of pregnancy, reducing the chance of her forgetting information on the chosen method and negating the need for a further appointment.

A method that has been quick started may be continued as an ongoing method of contraception or it may be used as a temporary 'bridging' method until pregnancy can be excluded and a longer-acting method initiated.

Table 1 highlights the additional contraceptive requirements when quick staring contraception. As with all other clients, all contraceptive methods should be discussed and STI risk assessment performed.

WHEN IS QUICK START APPROPRIATE

- If the health professional is reasonably sure that the woman is not pregnant (Appendix 1)
- If the health professional is reasonably sure that the woman is not at risk of pregnancy from recent unprotected sexual intercourse.
- If the woman wishes to start contraception immediately after emergency contraception
- If the woman is likely to continue to be at risk of pregnancy after emergency contraception

QUICK STARTING AFTER EMERGENCY CONTRACEPTION

When starting intrauterine methods or co-cyprindiol (Dianette®, Clairette®) health professionals should take particular care to exclude pregnancy or risk of pregnancy from recent UPSI. Women requesting the progestogen-only injectable should ideally be offered a bridging method if pregnancy cannot be excluded, but immediate start is acceptable if other methods are not appropriate or acceptable.

If risk of pregnancy cannot be reasonably excluded, the contraceptive provider should ensure that the woman is:

- Likely to continue to be at risk of pregnancy or that she has expressed a preference to begin contraception immediately
- Aware that there is a possibility of pregnancy
- Informed that there is a theoretical risk from fetal exposure to contraceptive hormones but most evidence indicates no harm
- Aware that pregnancy cannot be excluded until she has had a pregnancy test no sooner than 3 weeks after the last episode of unprotected sexual intercourse
- Provided with a pregnancy testing kit or informed of alternative options for pregnancy testing, including local providers of free testing
- Given advice on additional contraceptive precautions (Table 1)
- Offered a supply of condoms or informed of local providers of condoms
- Advised to return if there are any concerns or problems with her contraception

TABLE 1

SUMMARY OF ADDITIONAL CONTRACEPTIVE REQUIREMENTS WHEN STARTING CONTRACEPTION

Method	**Circumstances (day of menstrual cycle(a) /method of emergency contraception)**	**Requirements for additional contraception (condoms / avoidance of sex)**
Combined oral contraceptive pills /ring / patch (except Qlaira®)	Days 1-5 Day 6 onwards / Quick starting after POEC Quick starting after UPA EC	Not required 7 days 14 days
Qlaira combined oral contraceptive pill (b)	Day 1 Day 2 onwards/Quick starting after POEC Quick starting after UPA EC	Not required 9 days 16 days
Progestogen-only pill (traditional/desogestrel)	Days 1–5 Day 6 onwards / Quick starting after POEC Quick starting after UPA EC	Not required 2 days 9 days
Progestogen-only implant or injectable	Days 1–5 Day 6 onwards / Quick starting after POEC Quick starting after UPA EC	Not required 7 days 14 days
Levonorgestrel-releasing intrauterine system	Days 1–7	Not required
Copper-bearing intrauterine device	Any start day (c)	Not required

a) Day 1 defined as first day of menstrual bleeding; does not apply to withdrawal or unscheduled bleeding in women already established on hormonal contraception.
b) Recommendations according to Summary of Product Characteristics; currently no Faculty guidance on these methods.
c) Please refer to the IUD protocol if the copper IUD is being inserted as an emergency contraceptive

EC, emergency contraception
POEC, progestogen-only emergency contraception
UPA, ulipristal acetate.

DOCUMENTATION

The General Medical Council (GMC) advises that when prescribing a licensed medication for use outside the terms of the product licence:

- A clinician must be satisfied that there is sufficient evidence and/or experience of using the medicine to demonstrate its safety and efficacy.
- A clinician must make a clear, accurate and legible record of all medicines prescribed and, where you are not following *common practice*, the reasons for prescribing the medicine
- Where *current practice* supports the use of a medicine in this way it may not be necessary to draw attention to the licence when seeking consent.

The Nursing and Midwifery Council (NMC) advises that nurse or midwife independent prescribers may prescribe outside the product licence if they are satisfied that this better serves the patient/client's needs, and there is a sufficient evidence base. The patient/client should understand the reasons why such medicines are not licensed for this proposed use and this should be documented accordingly. The NMC also states it is acceptable for medicines used outside the terms of the licence to be included in patient group directions (PGDs) when such use is justified by current best clinical practice and the direction clearly describes the status of the product.

In a joint statement the Clinical Standards and Clinical Effectiveness Committees of the FSRH have agreed that CEU guidance on use of contraceptives is guidance on *"common practice"* and *"current practice"* in the use of these medicines and devices. Therefore, it is recommended that it may not be necessary for health professionals to document every occasion when a contraceptive preparation is prescribed outside the product licence if such use falls within current guidance issued by the CEU.

APPENDIX 1

Health professionals can be 'reasonably certain' that a woman is **not currently pregnant** if any one or more of the following criteria are met and there are no symptoms or signs of pregnancy:

- She has not had intercourse since last normal menses
- She has been correctly and consistently using a reliable method of contraception
- She is within the first 7 days of the onset of a normal menstrual period
- She is within 4 weeks postpartum for non-lactating women
- She is within the first 7 days post-abortion or miscarriage
- She is fully or nearly fully breastfeeding, amenorrhoeic, and less than 6 months postpartum

A pregnancy test, if available, adds weight to the exclusion of pregnancy, but only if ≥3 weeks since the last episode of unprotected sexual intercourse

If pregnancy is diagnosed after starting contraception and the woman wishes to continue with the pregnancy, the method should usually be stopped or removed. Women should be informed that contraceptive hormones are not thought to cause harm to the fetus and they should not be advised to terminate the pregnancy for this reason. Intrauterine contraceptives should not be removed if pregnancy is diagnosed after 12 weeks gestation.

If a woman is using the progestogen only implant and she opts to abort the pregnancy, the implant can be left in situ for ongoing contraception. There is a theoretical risk that progestogen from the implant may interact with the progesterone receptor antagonist, mifepristone, used in medical termination. However, there is no evidence that any interaction is clinically significant.

REFERENCES

FSRH CEU Clinical Guidance: Quick Starting Contraception. September 2010

With sincere thanks to the West of Scotland Sexual Health Managed Clinical Network for sharing their guidelines and protocols http://www.centralsexualhealth.org/west-of-scotland-managed-clinical-network