



What are the methods used in postcoital emergency contraception, positive and negative effects, limitations?

Nefise Nazlı Yenigül¹, Elif Yüce Bilgin¹

Department of Obstetrics and Gynecology, University of Health Sciences School of Medicine Bursa Yüksek İhtisas Research and Training Hospital, Bursa, Turkey

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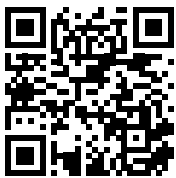
Dear Editor,

Postcoital emergency contraception (EC) refers to contraceptive options that can reduce the risk of pregnancy after sexual intercourse but before pregnancy occurs. It is not a primary method of contraception, sexually active patients of all ages can use it. Emergency contraception, prevention of unintended pregnancies, that supports families to have as many children as they want, when they want. EC can be a solution for elective curettage, which is an important public health problem. The use of oral drugs without a doctor's prescription is still a controversial issue.

Patients can administer emergency contraception in the form of oral preparations or intrauterine devices (IUDs). Administration of the copper IUD in the first five days after coitus was associated with 0% pregnancy in the next cycle [1]. However, Canadian guidelines set this period as 7 days [2]. The advantage of the IUD over other methods is that its effectiveness is independent of the timing of the menstrual cycle. It is the most effective EC method, but a visit to a health-care facility is required. The success of IUD containing levonorgestrel is similar to that of copper [3]. Ulipristal Acetate (UPA), a selective progestin receptor modulator, is the most commonly used oral EC.

It should be started within five days after the unintended intercourse. The advantage of UPA over other oral preparations is that it can delay ovulation even if the LH peak begins. Those with more than one episode of UPA use in their cycle are at the highest risk of pregnancy. IUD is more suitable for this group. It is recommended that the patient use a sexual abstinence or barrier method for at least 5 days after taking UPA. Hormonal contraception should not be started earlier than 5 days after taking UPA. Because of exposure to progestins for 7 days before and 5 days after UPA use may reduce the ovulation-blocking effect of UPA.

Another oral preparation is pill containing 1.5 mg of levonorgestrel (LGN). This oral preparation should be started within 72 hours after intercourse. It can prevent ovulation if used only before the LH peak. The risk of pregnancy increases with increasing BMI. In the publications, serum levels similar to LGN were found in obese patients and it was shown that dual use did not prevent ovulation [4]. Therefore, the use of double-dose LGN has no place in obese patients. The Yuzpe method, on the other hand, is an older EC. It contains 100 micrograms of EE + 0.5 mg of LNG. Repeat dosing is required at 12 hours. Nausea and



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Address for correspondence

Elif YÜCE BİLGİN, M.D., Department of Obstetrics and Gynecology, University of Health Sciences School of Medicine Bursa Yüksek İhtisas Research and Training Hospital, Bursa, Turkey. E-mail: elifyuce94@gmail.com

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vomiting is one of the most important disadvantages of using high-dose hormone. Preparations containing 4 mg Drosprenon, which are not yet available in our country but whose sales have started in Europe and America, also offer the advantage of cyclic use.

The only absolute contraindication for the use of EC is pregnancy. Current diagnosis of PID or uterine anomaly is a contraindication for IUD, and drug allergy is a contraindication for oral ECs. The lactation period is not restrictive for UPA or LNG use. Results of a study of UPA in mouse milk suggest discarding milk expressed for 24 hours [1], but no human data on UPA exposure in the newborn are available. LNG is minimally excreted in breast milk. EC has general side effects such as nausea, vomiting, spotting bleeding, and headache, but there is no significant difference between the methods in terms of these side effects. Data on side effects in repeated use are limited. In patients using oral EC, the menstrual cycle starts within an average of 1 week from the expected date.

Although emergency contraceptive methods prevent unwanted pregnancies, elective curettage rates have not decreased. This may be because they are not used after every unprotected sex, and current oral methods are only effective when used before ovulation. In order to clarify this issue, some new strategies regarding EC should be determined. The focus should be on maximizing the copper IUD in women with a history of recurrent EC use, facilitating the initiation of effective regular contraception after EC, and devel-

oping a more effective oral EC. In addition, patients who apply to the obstetrics clinic should be provided with information services to raise awareness on this issue.

Authors' Contribution

Study Conception: NNY,; Study Design: NNY,; Supervision: NNY,; Materials: EYB,; Data Collection and/or Processing: EYB,; Statistical Analysis and/or Data Interpretation: EYB,; Literature Review: NNY,; Manuscript Preparation: EYB and Critical Review: NNY.

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