The emergency intrauterine device: an endangered species

The use of the intrauterine device (IUD) as emergency contraception (EC) may be in danger of extinction. Is it still necessary now that hormonal EC is more widely available than ever before since its deregulation in 2001 from prescription-only medicine (POM) to pharmacy (P) status in the UK? Furthermore, the widespread development of Patient Group Directions has allowed nurses and other professionals to issue the POM without involving a doctor. Recent research supports simpler regimes for hormonal EC including 1.5 mg levonorgestrel in a stat dose, thus reducing the risk of non-compliance, and relaxing of the 72-hour rule. Nevertheless, women remain ill-informed about access and timing or are influenced by other factors leading to under use of the method. Doctors in primary care perceive the provision of emergency IUDs as expensive in terms of time and effort, and may be logistically difficult.

If 1000 women used an emergency IUD less than one would carry a risk of pregnancy. If 1000 women used hormonal EC somewhere between 15 and 30 would be pregnant. There is no doubt that the IUD is the most effective method of EC. It has a wider window for postcoital use, can be fitted up to 5 days after unprotected sex or up to 5 days from the earliest calculated day of ovulation, whichever is the longer. In addition, it offers reliable contraception from the moment of insertion onwards, potentially for many years, thus minimising the risk of unplanned pregnancy due to further episodes of user or method failure in the same or future cycles when the motivation to re-attend for hormonal treatment may be low.

A frequently raised concern with the use of the EC IUD is the growing awareness regarding sexually transmitted infections (STIs), in particular Chlamydia trachomatis. A recent study found a significantly higher incidence of Chlamydia in young women attending for EC compared to women attending for general contraception. The need for training and retaining the skills necessary to fit an IUD also form a barrier to its wider use. Do these obstacles push the EC IUD further along the road to extinction except in very specialist centres or via referral mechanisms across traditional boundaries between general practices, family planning clinics, and Primary Care Trusts.

Finally, these considerations should not distract from the fact that in the end the use of an emergency IUD should be the result of informed choice by the woman. At present we are still a long way from offering either full information or choice.

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References


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