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Survey of Emergency Physicians regarding Emergency Contraception

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To the Editor

Emergency contraception (EC) offers women the option of preventing undesired pregnancy after unprotected sexual intercourse, suspected contraceptive failure, or sexual assault. It is not uncommon for patients to present to the emergency department (ED) requesting EC.(1) Currently, there are several different EC options available to patients in the US including two doses of an estrogen-progesterone combination, known as the Yuzpe method, a progesterone-only regimen using levonorgestrel (Plan B®), and placement of an intrauterine device (IUD), which offers the advantage of continued contraception if kept in place.(2) In 2010, the US Food and Drug Administration approved ulipristal acetate (UPA) for use as an EC method.(3) UPA, a selective progesterone receptor modulator, is available by prescription only and has been shown to be highly effective for up to 120 hours after coitus. (4) UPA has been shown to be more effective in preventing undesired pregnancy than levonorgestrel, particularly in women with high body mass index.(5–7) It is unclear if emergency providers (EPs) are aware of, or are using, UPA for women presenting to the ED. We sought to assess EP behaviors regarding types of EC offered to patients.

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We developed a simple 5-item survey instrument (see Appendix) which assessed EP awareness and behavior regarding different types of EC. Pilot-testing was performed with a small group of EPs at our institution to refine the survey instrument for clarity and ease of use. A purposive convenience sample of EPs was recruited via email to participate in a telephone survey. After verbal consent was obtained, basic demographic information was collected. Survey questions assessed awareness and self-reported practice patterns related to levonorgestrel, UPA, and IUD placement. The telephone survey lasted roughly 4–5 minutes and was performed by two of the authors (LL, MP). Survey data were collected in a web-based electronic database and basic descriptive statistics were performed using STATA (version 13.1; StataCorp LP, College Station, TX). The survey study was approved by the Institutional Review Board at our institution.

Of the 63 EPs contacted via email, 50 completed the phone survey for a response rate of 79%. The mean age of respondents was 37 years (range 30–62 years); 74% were male and half were practicing in an academic hospital. Respondents worked at 43 institutions in 15 different states (see Table).

When asked what form of EC they would offer female patients seeking such therapy, 40 (80%) would offer levonorgestrel, two (4%) would offer IUD placement, and none (0%) would offer UPA. The remaining eight (16%) respondents reported that they would need to verify what was available in their department (see Table). When asked specifically if they had ever offered UPA, 0 out of 50 respondents answered “yes”.

In a cross-sectional survey of EPs practicing in the US, we found that most EPs offered levonorgestrel-based EC, a small minority offered IUD placement, and none offered UPA.

Despite evidence that UPA is more effective in preventing unintended pregnancy than levonorgestrel EC, none of the EPs surveyed indicated they would offer it to patients. The exclusion of UPA is of particular concern for patients seeking EC greater than 72 hours after unprotected intercourse and those with higher BMI, because it is effective for up to 120 hours and has been shown to be more effective than levonorgestrel in obese women.⁽⁸⁾

Of note, 4% of EPs in our sample offered IUD placement. Copper IUD insertion within 5 days of unprotected intercourse is the most effective form of EC, and the only option that provides safe and effective long-term contraception for up to 12 years. Of note, IUD insertion is generally not within the standard scope of emergency medicine practice; however, patients could be referred to other providers for insertion.

Limitations of this study include the non-random, and relatively small, sample of respondents recruited. Nonetheless, the fact that fewer than 5% of EPs would offer a non-levonorgestrel option for EC and no provider in our sample would offer UPA suggests that even in a larger, random sample of EPs, EC prescribing patterns would favor levonorgestrel over UPA.

The findings of our study suggest that EPs in the US are less likely to offer UPA or the copper IUD as an option for EC, despite its demonstrated superiority over other agents such

as levonorgestrel. Dissemination and implementation efforts aimed at increasing awareness and use of alternate EC options are needed.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table

Results of Emergency Contraception Survey among Emergency Physicians

Demographics	Number (%) or Mean	
Age in years, mean (range)	37 (30–72)	
Gender	Female 13 (26%)	Male 37 (74%)
Clinical Experience		
Years in practice: mean (range)	5.6 (2–31)	
Board Certified	Yes: 44 (88%)	No: 6 (12%)
Practice Type		
University/Teaching	26 (52%)	
Community	24 (48%)	
Emergency Contraception offered		
Levonorgestrel(Plan B)	40 (80%)	
IUD	2 (4%)	
Norgestrel/estradiol (Ovral)	1 (2%)	
Ulipristal(Ella)	0 (0%)	
Consult formulary	8 (16%)	

IUD: Intrauterine device.