menstrual history. However, we frequently rely on such a calculation when deciding whether an intrauterine device (IUD) can be fitted as an emergency contraceptive. Maybe in light of the evidence supplied in their letter this practice should be reviewed? If we accept that menstrual history can be used to guide the timing of ovulation in relation to EC, then recognising the significant cost differential between UA and levonorgestrel and UA's proposed superior ability to delay/inhibit ovulation, maybe there is an opportunity to use UA 'smarter' around the proposed time of ovulation when an IUD is declined.

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Ulipristal acetate emergency contraception

I read with interest the letter by Webb *et al*.[1] about the pitfalls of adapting the Clinical Effectiveness Unit's guidance on emergency contraception (EC).[2] Their letter discusses, in relation to maximising the pharmacodynamic attributes of ulipristal acetate (UA), the significant inaccuracies inherent in the calculation of the timing of ovulation based on the