

# 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,<sup>1</sup> and relaxing of the 72-hour rule.<sup>2</sup> Nevertheless, women remain ill-informed about access and timing<sup>3</sup> or are influenced by other factors leading to under use of the method.<sup>4</sup> Doctors in primary care perceive the provision of emergency IUDs as expensive in terms of time and effort, and may be logistically difficult.<sup>5</sup>

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.<sup>6</sup> 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.<sup>7</sup> 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.<sup>8</sup> The need for training and retaining the skills necessary to fit an IUD also form a barrier to its wider use.<sup>5</sup> Do these obstacles push the EC IUD further along the road to extinction except in very select, specialist hands? Will the method be completely superseded by the perceived ease of distributing the less invasive, ever more simplified hormonal option?

But is it truly so much easier to provide hormonal methods? Ideally a consultation regarding EC should assess the risk of pregnancy and STIs in an open, non-judgmental way. Testing for STIs should be carried out as appropriate. The availability of less invasive tests which are highly sensitive and capable of detecting very small numbers of pathogens soon after infection<sup>8</sup> will hopefully increase uptake of testing and thus improve detection and treatment, irrespective of the chosen method of EC. Cover for *Chlamydia* can be given with a single-dose treatment. No consultation on EC is complete unless ongoing contraception has been discussed and provided if the woman wishes. The provision of an IUD can cover all these areas. The extra time required for the fitting may be balanced by the reduced likelihood of re-attendance for further episodes, or the need to explain the use of the pill or other methods, or dealing with the consequences of unplanned conception.

The implementation of the National Sexual Health Strategy<sup>9</sup> with its envisaged development of primary care settings providing Level 2 care<sup>9</sup> which includes insertion of IUDs provides an ideal opportunity to improve services. Locally adaptable referral pathways with direct and rapid

access for women requesting to have EC IUDs fitted may thus improve availability and accessibility. Clinicians willing to offer Level 2 service may be more likely to have a positive attitude, be motivated and well trained, thus reducing the risks associated with IUD insertion.

The emergency IUD will never replace the hormonal option, but there will always be a group of women for whom this method is ideal – not just at the time of their need – but also for ongoing contraception. Women have a right to know of this much more effective option and providers have a responsibility to reflect on their own attitude towards IUDs<sup>10</sup> and to regularly update their knowledge and skills. The method also needs to be better publicised and presented in a more objective way that allows women to weigh up the advantages and disadvantages, even before they access services. On a local level, health care providers need to develop strategies to improve access at convenient times and locations, whether through new provision in 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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