Comment on 'An emergency contraception algorithm based on risk assessment: changes in clinicians' practice and patients' choices'

As with McKay and Gilbert[1] in Cambridge, UK, we also developed an emergency contraception (EC) algorithm following the introduction of ulipristal acetate (UPA), likewise recognising that fitting an intrauterine device (IUD) was the 'gold standard'. Our ongoing experience is rather different, however, in that our rates of emergency IUD fitting have increased since the introduction of our algorithm from 6% to at least 9%.

Within the Department of Sexual and Reproductive Healthcare in Aneurin Bevan Health Board (South Wales), 6% (17/270) of clients leaving the clinic with a method of EC in 2011 had an IUD fitted. Our service is different to the one in Cambridge in that our clients can usually have an IUD fitted on the day of presentation providing there is an IUD fitter in clinic. Thus a second appointment is not needed.

Although there is no recognised standard for the percentage of emergency IUDs fitted, Schwarz *et al.*[2] found that 12% of women attending a walk-in clinic for either pregnancy testing or EC would consider same-day fitting of an IUD, and a further 22% expressed interest in having further information about the IUD, suggesting that our emergency IUD insertion rates could be improved. We therefore ran a teaching session in January 2012 to emphasise the efficacy and benefits of emergency IUDs to nursing staff, and between March and May 2012 introduced our algorithm for EC, including the use of UPA. Our algorithm is similar to that used in Cambridge but we consider the high-risk time for conception to be Days 10–15 of the cycle, and our algorithm is designed so that staff must record that they have discussed the emergency IUD. In the 3 months following the intensive teaching programme our rate of emergency IUD use increased to 11.8%. Disappointingly, however, for the 9 months to the end of 2012 the rate dropped to an average of 9%.

We audited the notes of all clients given EC between May and July 2012 and found that 31% of clients had been inaccurately recorded as unsuitable for the IUD. In a further 11% of cases we could not assess suitability for an IUD from the information provided. Consequently, further teaching was undertaken to explain to staff when clients may have an emergency IUD fitted, and the clinical proforma was amended so that staff had to give reasons why the client was unsuitable for an IUD.

An audit for the first 3 months of 2013 demonstrates a small increase in emergency IUD use to 10.5%. As well as being encouraging, this suggests that clinician advice to clients is influential in their choice of EC. As many of our clients have little or no knowledge of the emergency IUD[3 4] and a possibly inflated estimate of the effectiveness of oral EC,[5] it is also incumbent upon the clinician to give appropriate risk management advice.[6]

In summary, our experience of introducing a new EC pathway that includes UPA has been an increase in the rate of clients using emergency IUD contraception from 6% to at least 9%. It is noteworthy that our initial rate of emergency IUD use was far lower than in Cambridge but our current endpoint is similar. We will continue auditing emergency IUD use to see if we can sustain, or improve on, our current usage. If this small effect were to be replicated nationally, this would constitute a clinically important increase in long-acting reversible contraception use and more cost-effective contraception[7] – a definite bonus in these financially stretched times.

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