West of Scotland Guideline *Approved June 2020*

QUICK STARTING CONTRACEPTION

What's New
There are no changes to this Guidance since the previous update.

Background

Quick starting (QS) is the immediate initiation of a contraceptive method at the time a woman requests it, rather than waiting for the next natural menstrual period.

This practice may be outside the product licence / device instructions of the chosen method, but may have potential benefits such as reducing the time she is at risk of pregnancy, reducing the chance of her forgetting information on the chosen method and negating the need for a further appointment.

A method that has been quick started may be continued as an ongoing method of contraception or it may be used as a temporary 'bridging' method until her preferred method can be commenced (e.g. pregnancy excluded).

Table 1 highlights the additional contraceptive requirements when quick starting contraception. As with every client, all contraceptive methods should be discussed and STI risk assessment performed.

a) Quick Starting if pregnancy can be excluded

- Any method of contraception can be quick started at any time in the menstrual cycle if it is reasonably certain that a woman is not pregnant or at risk of pregnancy from recent unprotected sexual intercourse (UPSI). See below.

- HCPs can be 'reasonably certain' that a woman is **not currently pregnant** if any one or more of the following criteria are met and there are no symptoms or signs of pregnancy:

    - No intercourse since last normal (natural) menses, since childbirth, abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
    - Correctly and consistently using a reliable method of contraception
    - Within the first 5 days of the onset of a normal menstrual period
    - Less than 21 days post-partum (non-breast feeding women)
    - Fully breast feeding, amenorrhoeic and less than 6 months post partum
    - Within the first 5 days after abortion, miscarriage, ectopic or uterine evacuation for gestational trophoblastic disease.
    - No intercourse for >21 days and has a negative high sensitivity urine pregnancy test (HSUPT) (able to detect hcg levels around 20mIU/ml).

b) QS if pregnancy cannot be excluded

- Women who have a negative HSUPT but are at risk of pregnancy from recent UPSI should be advised that:

    - Emergency contraception may be indicated.

    - Contraceptive hormones are not thought to cause harm to the fetus and they should not be advised to terminate pregnancy on the grounds of exposure.

    - Additional contraceptive precautions (barrier or abstinence) are required until the quick started contraceptive method becomes effective. See table 2.

- A follow up pregnancy test is required no sooner than 21 days after the last UPSI. Provide a pregnancy testing kit or inform of alternative options for pregnancy testing, including local providers of free testing.

- She should return if there are any concerns or problems with contraception.

Pregnancy diagnosed after Quick starting contraception

FSRH Guidance advises that women should be informed that contraceptive hormones are not thought to cause harm to the fetus and they should not be advised to terminate pregnancy on the grounds of exposure.

Wish to continue with the pregnancy (using CHC, POP, IMP, DMPA)

- CHC or POP should be stopped immediately. Implants should be removed promptly if a pregnancy is diagnosed after starting contraception.

Choose not to continue with the pregnancy

- **IMP or DMPA:**
  Women can continue the method of contraception with no additional contraception precautions after abortion. If DMPA administered at time of mifepristone there may be a slightly higher risk of continuing pregnancy (failed termination).

- **CHC or POP:**
  Women should stop method and restart contraception immediately after abortion with no additional contraception requirements.

- **Using intrauterine contraception (IUC)**
  HCPs should advise women whose intrauterine pregnancy is less than 12 weeks gestation that IUC should be removed, as long as the threads are visible or it can be easily removed from the endocervical canal. This is regardless of whether the woman decides to continue with the pregnancy or not. The risk of adverse intrauterine pregnancy events are greater with an IUC insitu compared to those without. IUC removal in first trimester could improve pregnancy outcomes, but it is associated with a small risk of miscarriage.

Documentation

Quick Starting hormonal contraception without being reasonably sure pregnancy is excluded is outside the terms of the product license, however the FSRH support QS contraception as outlined in their guidance.

The General Medical Council (GMC, 2013) advises that when prescribing a licensed medication for use outside the terms of the product licence:

In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population.

The Nursing and Midwifery Council (NMC, 2015)) advises that nurse or midwife independent prescribers may prescribe outside the product licence if they are satisfied that this better serves the patient/client's needs, and there is a sufficient evidence base. The patient/client should understand the reasons why such medicines are not licensed for this proposed use and this should be documented accordingly.

The NMC also states it is acceptable for medicines used outside the terms of the licence to be included in patient group directions (PGDs) when such use is justified by current best clinical practice and the direction clearly describes the status of the product.

Table 1: Summary of methods which can be quick started

Situation	Quick Starting
Normal menstruating woman No pregnancy risk this cycle	All methods can be considered
Normal menstruating woman Pregnancy risk this cycle Not taken Emergency contraception	All methods except any combined hormonal contraception containing cyproterone *or* any levonorgestrel intra-uterine system
Following levonorgestrel emergency contraception	All methods except any combined hormonal contraception containing cyproterone *or* any levonorgestrel intra-uterine system
Following ulipristal acetate emergency contraception	All methods **BUT** must wait 5 days before starting any hormonal containing contraception

Table 2: Summary of additional contraceptive requirements when starting contraception.

NB: After ulipristal acetate emergency contraception wait at least **5 days** before starting any hormonal contraception

Method	**Day of Menstrual Cycle ***	**Days of additional contraception required after starting method (condoms/abstinence)**
Combined Hormonal contraception (except Qlaira®/Zoely®)	Days 1-5 Day 6 onwards	None 7
Zoely® COC	Day 1 Day 2 onwards	None 7
Qlaira® COC	Day 1 Day 2 onwards	None 9
Progestogen-only pill	Days 1-5 Day 6 onwards	None 2
Implant or Depot medroxyprogesterone	Days 1-5 Day 6 onwards	None 7
Levonorgestrel Intra-uterine system	Days 1-7 Day 8 onwards	None 7
Copper Intra-uterine Device (See emergency contraception protocol if this is the indication for insertion)	Any day	none

***** Day 1 defined as first day of menstrual bleeding; does not apply to withdrawal or unscheduled bleeding in women already established on hormonal contraception

References

FSRH Quick Starting Contraception. April 2017. Available from: www.fsrh.org/standards-and-guidance/current-clinical-guidance/quick-starting-contraception/ [accessed online June 2020]

GMC Good practice in prescribing and managing medicines and devices 2013: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices

NMC Standards for medicines management 2015: https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-medicines-management/