CD Summary

May 21, 2002
Vol. 51, No. 11

Telephone 503/731-4024
Emergencies 503/731-4030
Fax 503/731-4798
cd.summary@state.or.us
www.oshd.org/cdpe/

AN EPIDEMIOLOGY PUBLICATION OF THE OREGON DEPARTMENT OF HUMAN SERVICES

EMERGENCY CONTRACEPTION PILLS AND THE NEED FOR ADVANCE PRESCRIPTIONS

UNINTENDED pregnancy is associated with late initiation of prenatal care, low birthweight, domestic violence and poor child health and development.[1] Oregon survey and birth certificate data indicate that more than half of all Oregon pregnancies are unintended, and that over 40% of those unintended pregnancies end in abortion. Emergency contraception could potentially prevent half of unintended pregnancies.[2] This *CD Summary* discusses emergency contraception (EC) and several strategies for increasing women's access to EC.

WHAT IS EMERGENCY CONTRACEPTION?

EC has been available since the early 1970s. Emergency contraceptive pills prevent pregnancy the same way that daily birth control pills do—by delaying or preventing ovulation, inhibiting fertilization or preventing implantation of the fertilized ovum.[3] They are not to be confused with Mifeprex (also known as RU-486 or mifepristone). Once a pregnancy is established, EC will not harm the developing fetus.

The original regimen approved for EC contained a combination of estrogen and progestin. However, in 1999, the FDA approved a progestin-only regimen (two doses of 0.75 mg of levonorgestrel taken 12 hours apart) under the brand name *Plan B. Plan B* is more effective and has fewer side effects (particularly much reduced nausea and vomiting) than the original regimen,[4] and should therefore be the EC regimen of choice for most situations. In addition, although it was recommended that the original regimen be prescribed with an antiemetic, the low incidence of nausea and vomiting with *Plan B* means that prescription of an antiemetic together with *Plan B* is not routinely indicated.

EC pills can reduce the risk of pregnancy by 75–89% (without EC pills 8% of women with unprotected mid-cycle intercourse would become pregnant; with EC pills only 2% would become pregnant).[2] EC therapy is most effective when taken in the first 24 hours after intercourse. Although effectiveness decreases with time after intercourse, it may be effective in some cases up to five days after intercourse.

IMPROVING ACCESS TO EC

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a DHS Office of Family Health survey of new mothers.[5] In 1998–99, PRAMS found that 30% of new mothers reported not having heard of EC. The women most likely to have not heard about EC (in multivariate analysis) were mothers with less than a high school education, with an annual family income below $30,000, and whose pregnancies were unintended (see table). These demographic characteristics describe a group of women for whom education about the availability of emergency contraception should be a priority.

One way to increase access to EC is for providers to supply female patients with advance prescriptions for EC at routine visits. Some providers have expressed concerns that advance prescriptions may lead to reliance on EC as a birth control method.[6] However, a randomized trial found that women who had emergency contraceptive pills in their home were not more likely than the control group (who had to go to a doctor to obtain EC) to use it more than once.[7]

Another strategy to improve access to EC is to make it available directly from pharmacists. Since 1998, Washington State has allowed pharmacists, under the aegis of a collaborative drug therapy agreement, to evaluate a patient's need for EC and provide counseling, referrals and EC pills, if appropriate. Over 50,000 women have accessed EC from Washington pharmacists since 1998, and surveys of physicians and patients have shown strong support. Pharmacist-dispensed EC may have caused the subsequent decrease in abortions and unintended pregnancies in Washington.[8,9] California enacted a similar law in 2001. Although there was discussion during the Oregon 2001 legislative session about how to allow pharmacist dispensing of EC, no bill was passed relating to this topic.

Risk factors for not having heard of emergency contraception, multivariate analysis, Oregon PRAMS, 1998–99

Risk Factor		Multivariate OR_a (95% Confidence Interval)
Maternal education <12 years	(a)	3.23 (2.17, 5.00)
Annual family income <$30,000	(b)	2.04 (1.39, 3.03)
Unintended pregnancy	(c)	1.47 (1.03, 2.08)

(a) compared to ⩾12 years (b) compared to ⩾$30,000 (c) compared to intended pregnancy

WHAT PROVIDERS CAN DO

Providers should inform their patients about EC as an option in case of contraceptive failure or unprotected sex. Providers should not rely on their patients asking for EC, and any woman of reproductive age should be asked if she knows about EC, and offered EC information and a prescription if appropriate. Health-care providers at college health clinics can educate students about EC and expedite access. Emergency-department providers can inform rape victims about EC. EC can safely be prescribed over the phone without an exam, since neither possible pregnancy nor any STD is a contraindication for EC. To improve awareness about EC, providers can prominently display brochures and pamphlets about EC in their waiting rooms. Special effort should be given to educating low-income women and women with less than a high school education about EC.

Providers can order *Plan B* and/or preprinted prescription pads directly from the manufacturer, Women's Capital Corporation (1-800-330-1271; info@go2planB.com). Their web site (*http://www.go2planB.com* ["Tools for Clinicians"; "Pharmacy Directory"]) lists some of the retail pharmacies that stock *Plan B*.

Additional information about EC is available from DHS' Office of Family Health at 503/731-4507.

The **CD Summary** (ISSN 0744-7035) is published biweekly, free of charge, by the Oregon Dept. of Human Services, Office of Communicable Disease and Epidemiology, 800 NE Oregon St., Portland, OR 97232
Periodicals postage paid at Portland, Oregon.
Postmaster—send address changes to:
CD Summary, 800 NE Oregon St., Suite 730, Portland, OR 97232

CD SUMMARY

May 21, 2002
Vol. 51, No. 11

PERIODICALS
POSTAGE
PAID
Portland, Oregon

DHS

If you need this material in an alternate format, call us at 503/731-4024.

IF YOU WOULD PREFER to have your *CD Summary* delivered by e-mail, zap your request to *cd.summary@state.or.us*. Please include your full name and address (not just your e-mail address), so that we can effectively purge you from our print mailing list, thus helping to save trees, taxpayer dollars, postal worker injuries, etc.

REFERENCES

1. Brown SS, Eisenberg L, eds. The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. Institute of Medicine. National Academy Press, Washington, DC, 1995.
2. Van Look PF, Stewart F. Emergency Contraception. In: Hatcher RA, Trussell J, Stewart F, Cates W Jr, et al., eds. Contraceptive Technology. New York: Ardent Media; 1998:277–95.
3. Grou F, Rodrigues I. The morning-after pill—how long after? Am J Obstet Gynecol. 1994;171:1529–34.
4. World Health Organization: Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. Lancet. 1998;352:428–33.
5. Web site: *http://www.oshd.org/pcah/prams1.htm*.
6. Gold MA, Schein A, Coupey SM. Emergency contraception: a national survey of adolescent health experts. Fam Plann Perspect. 1997;29:15–19.
7. Glasier A, Baird D. The effects of self-administering emergency contraception. N Engl J Med. 1998;339:1–4.
8. Wells ES, Hutchings J, Gardner JS, Winkler JL, et al. Using pharmacies in Washington state to expand access to emergency contraception. Fam Plann Perspect. 1998;30:288–90.
9. Gardner JS, Hutchings J, Fuller TS, Downing D. Increasing access to emergency contraception through community pharmacies: lessons from Washington State. Fam Plann Perspect. 2001:33:172–75.

Influenza Departs Oregon

THIS PAST SEASON influenza type A (H3N2) viruses predominated in Oregon with the first case reported during the 9th week (ending 12/01/01) of the influenza epidemiologic year by staff of the Providence Portland Medical Center Infectious Disease Laboratory and the last case was reported in week 27 (ending 04/06/02) by Clinical Epidemiologists of Legacy Health System. In addition to these two sources, reports were received from the Oregon State Public Health Laboratory (OSPHL). Considering all sources of culture-positive reports, this season's tally came to 115 isolates—five type B isolates and 110 type A. Last season's tally climbed to 133 isolates by this same time—52 type A and 81 type B. Onsets of illness peaked at 14 during week Feb. 10–16.

Review of OSPHL reports for the last 10 seasons dating back to 1991–92 reveals a continuing trend toward less vindictive influenza viruses. The number of "R/O flu" specimens examined for influenza virus came to 377 with 44 (12%) positive. The number of cultured specimens ranked third with only two seasons having lower totals. The same third place ranking emerged when comparing the number of isolates and percentage positive. The one feature seeking recognition was the duration of 19 weeks—which ranked as the third longest; the1994–95 season lasted 20 weeks and the 1992–93 season 26 weeks.

Highlights of the season in the U.S. consisted of identification of reassortment H1N2 viruses and viruses of the B/Victoria lineage not seen here since 1991. The H1N2 viruses did not pose any threat as the current vaccine proved as effective against them as the circulating H1N1 and H3N2 viruses. The appearance of the viruses of the B/Victoria lineage led to the change in the B component of the vaccine recommended for the next season.

This season, Oregon surveillance efforts were bolstered by 22 sentinel practitioners. On average 1.5% of patients seen each week had influenza-like illness (ILI). ILI peaked at 3.0% during the week of February 3–9.

Thanks to all who participated in our surveillance activities, including the sentinal reporters! Resumption of surveillance for the 2002–2003 season will be announced in the fall on these pages. In the meantime, we have a wealth of influenza info, including recommendations for the coming season, on our influenza website: *http://www.oshd.org/acd/docs/influenza.htm*.

Lockdown — *NOT*

MAY 16TH'S ENTERTAINING and dramatic episode of *ER* unfortunately portrayed the public health response to a smallpox outbreak inaccurately. In particular, we public-health types in Oregon do not envision a scenario in which we would advise the "lockdown" of an emergency department.

Were smallpox to be reintroduced we would advise isolation of febrile patients and rapid vaccination of household and face-to-face contacts. Contacts would be discharged from the emergency department and contacted daily to see if they had developed a fever and therefore required isolation.

Please note the distinction between *isolation* of febrile patients, which we would employ, and *quarantine*, which we would *not* employ. Quarantine involves large-scale restriction of movement and cohorting of ill and well people together; it may well increase the exposure of many to disease, would be difficult to enforce, and has historically been ineffective. History *has* shown us that smallpox is controllable by contact tracing and ring vaccination.

For vaccine supply updates go to *www.healthoregon.org/imm/provider/welcome.htm*