

MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM
PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY
DEPARTMENT CLINICIANS

SECTION VII

EMERGENCY CONTRACEPTION

- Emergency contraception is indicated within 120 hours post-assault but should be administered as soon as possible post-assault to maximize efficacy.
- All patients capable of pregnancy must be offered information about the option of emergency contraception (EC) at the time of their Emergency Department visit **regardless of gender expression**.
- EC should be offered and administered **whether or not** the patient chooses to complete the Massachusetts Sexual Assault Evidence Collection Kit (MSAECK) or report their assault to law enforcement.
- The most effective EC regimen for all patients regardless of weight is emergency insertion of a Copper T Intrauterine Device (IUD), although this method may not be indicated or tolerated by all patients. A supportive referral for same-day IUD insertion may be provided by calling the Family Planning Patient Navigation Line at 617-616-1636.
- Ulipristal Acetate (UPA) is the preferred first-line choice for EC treatment for a sexual assault patient at a SANE designated hospital. Levonorgestrel (LNG) EC products are also endorsed when UPA is unavailable or contraindicated.
- Baseline pregnancy testing should be offered in the ED. However, if a patient does not consent to be tested for pregnancy, they should still be offered EC as there are no contraindications in cases of rape.
- In cases in which a patient does not consent to pregnancy testing, the decision of which EC product to use should be guided by an assessment of risk of current pregnancy, and informed discussion of EC products including the respective body of knowledge regarding effects of EC on current pregnancy.
- If there are any incidents in which a medical provider will not prescribe or give EC, it is in the SANE's purview to access other responsible hospital authorities who are **required by law** to ensure that patients receive EC.

Assessing for Existing Pregnancy

- All patients capable of pregnancy should ideally be screened for pre-existing pregnancy as part of post-assault medical care. However, if a patient does not consent to pregnancy testing they should still be offered emergency contraception as there are no restrictions for use in cases of rape. In addition, Massachusetts law requires hospitals to offer and initiate EC upon request for all sexual assault victims of childbearing age.
- Pregnancy testing will help to determine the most appropriate provider to perform a speculum exam for purposes of a comprehensive medical-forensic exam, and help to guide decision-making regarding HIV and STI prophylaxis in the case of existing pregnancy.
- The SANE should educate the patient that the current pregnancy test results will reflect only the patient's baseline, and will **not** show a positive pregnancy result from an assault that occurred within the past 120 hours.
- A STAT urine hCG test is the preferred method of pregnancy testing. The test used should have a 25ml U/hCG sensitivity or lower. The results of the test should be documented on MSAECK Form 7.
- If the patient tests positive for a pre-existing pregnancy, consult with the ED or OB/GYN provider prior to proceeding with the SANE examination. All pregnant patients should have the speculum exam complete by an ED or OB/GYN provider if indicated for medical care and forensic evidence collection...

Protocol for Offering Emergency Contraception

- Patients with a uterus and at least one ovary are capable of becoming pregnant beginning two weeks prior to the patient's *first* menstrual cycle until they reach menopause, unless they are currently pregnant.
- Review the history of assault related to pregnancy risk with the patient—type of assault, ejaculation, use of a condom, current contraceptive use, etc. While determination of LMP is done as part of routine medical care, many patients (and trauma survivors in particular) may be unable to provide a reliable LMP or may begin to experience problems with birth control compliance following an assault. Additionally, while there

MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

are many highly effective contraceptive methods, no contraceptive method is 100% effective. **Therefore, all patients capable of pregnancy should be offered EC regardless of LMP or birth control method use.**

- Review the MDPH EC fact sheets for survivors with patient and initiate EC.
<https://www.mass.gov/emergency-contraception-for-hospital-emergency-departments>
- Patients are not required to complete any part of the sexual assault evidence collection kit (MSAECK) or to file a police report as a condition for the provision of EC.

If assault occurred more than 120 hours ago, or if the patient declines EC:

- Do not give emergency contraception. If the patient has declined EC, the ED Physician should review potential for pregnancy based on patient's history and LMP.
- Instruct the patient to obtain a repeat pregnancy test 14 or more days after ED visit.
- Consult with ED or OB/GYN physician for appropriate referral and timing of follow-up.
- Document reason EC was not given on Form 2A PSCR and on Form 7.
- Encourage the patient to contact their primary care provider, women's health provider, or family planning clinic for follow-up and to discuss birth control and STD/HIV prevention.

Emergency Contraception Options (See [Appendix 5](#))

- The Copper T IUD is 99.9% effective at preventing pregnancy when inserted up to 5 days after unprotected sex. It is a highly effective, immediate, and cost-effective ongoing method of birth control for up to ten years post-insertion.
- The efficacy of the Copper T IUD is not affected by oral emergency contraception options. Therefore even patients who are considering a Copper T IUD as emergency contraception after their ED visit should be offered oral EC.
- UPA is the most effective oral medication available for preventing pregnancy after unprotected sex. UPA has been shown to result in pregnancy rates up to 65% lower than LNG when administered in the first 24 hours after unprotected sex, and up to 42% lower than LNG when administered up to 72 hours after unprotected sex.
- If LNG is taken within 72 hours of assault, it prevents pregnancy 89% of the time. If taken between 72-120 hours, it prevents pregnancy 72-87% of the time. For every 12 hours that a patient delays initiation of LNG, their chances of becoming pregnant increase by almost 50%. Patients should be informed that LNG is more effective the sooner it is taken and most effective if taken within the first 12 hours after sexual assault. Unlike LNG, the efficacy of UPA **does not** decline during the five days following unprotected sex.
- If a patient's weight is greater than 165 pounds, the efficacy of either UPA or LNG EC may decrease. However, but the effect of the patient's weight on UPA efficacy is less than the effect of weight on LNG efficacy. While patients greater than 165 pounds may increase their odds of pregnancy prevention by choosing UPA or a Copper T IUD for EC, they should not be denied access to LNG products especially if more effective options are not available, clinically indicated, or acceptable to the patient.
- Patients who are using hormonal contraception should be counseled regarding potential interactions with UPA that may affect efficacy and when to start or restart their method in relationship to UPA dosing.
- Patients should be counseled regarding drug interactions between current medications and oral EC medications. Current medications may decrease EC efficacy, but patients should not be denied access to EC based on the effects of these medications.
- The ED must promptly offer and provide UPA (or LNG) EC pills at the facility at time of patient's visit. A **full course** of EC pills—not a prescription—must be provided to patients onsite at the time of the patient's visit.

Administer Pregnancy Prophylaxis Medication

- **Pregnancy prophylaxis is indicated within 120 post-assault**; however, the efficacy of EC is time sensitive. Administer this medication as soon as possible within the medical encounter.
- The following is the recommended treatment for pregnancy prophylaxis based on best practices in the care of sexual assault patients. This treatment takes into account the recommended combination of antibiotics and antiretroviral medications that may be prescribed for comprehensive treatment. Such consideration also includes the fact that progestin-only products are known to cause fewer side effects (such as nausea and

MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

vomiting) and are also known to be the most effective type of EC. Ulipristal acetate (UPA) is the preferred first-line choice for EC treatment for a sexual assault patient at a SANE designated hospital. Other EC products are also listed as follows:

Emergency Contraception Dosage, United States FDA-Approved Products for EC indicated by mouth (single dose)			
Product	Brand	Tablets per Dose	Dose
Ulipristal acetate (UPA)	ella [®]	1 tablet per dose	30 mg ulipristal acetate
Levonorgestrel (LNG)	Plan B One-Step [®] ; MyWay [®] ; Take Action [™] ; Next Choice One Dose [®] ; AfterPill [™]	1 tablet per dose	1.5 mg levonorgestrel

- **Safety:** If LNG is taken when the patient is pregnant or if pregnancy occurs despite use, LNG will not harm the developing fetus. Growing evidence also shows that UPA will not harm an ongoing pregnancy; however this evidence is not yet conclusive and should be discussed.
- **Contraindications:** Known established pregnancy reported by the patient. Known hypersensitivity to any component of the product. According to the World Health Organization, there are no restrictions for use in the case of rape. If upon request of the patient, capable of pregnancy, the ED does not initiate emergency contraception the contraindication(s) **must** be documented on the PSCR (Form 2A) and on Form 7.

Side Effect Management

- Although not common with progestin-only EC, nausea and vomiting may occur.
- If vomiting occurs within two hours of administration, an antiemetic per direction of ED Physician may be considered and the EC dose should be repeated.
- Prescribing an antiemetic 30 minutes prior to patient receiving medications **should be considered** taking into account the combination of antibiotics, EC, and possibly antiretroviral medications.
- If patient vomits during ED visit, please refer to Primary Nurse and ED Provider regarding further treatment for nausea and medication management.

Patient Counseling and Follow-up

- Ensure the patient was provided with the emergency contraception fact sheet entitled “Emergency Contraception after Sexual Assault: Five Key facts for Survivors” which is found in the MSAECK Patient Information Packet and available online in several languages at: www.mass.gov/emergencycontraception.
- Explain to the patient that after oral EC their next period may be heavier or lighter than normal, and that it may start earlier or later than expected depending upon where they are in their cycle. The majority of patients should receive their next menses at the expected time or within \pm 7 days.
- The patient should obtain a repeat pregnancy test in 1 month after taking oral emergency contraception as instructed on the Form 7 Discharge Planning Form.
- If patient experiences severe lower abdominal pain 3-5 weeks after EC administration, they should be evaluated for ectopic pregnancy.
- Patients currently using hormonal contraception should be counseled regarding potential interactions with UPA and when the patient should initiate or resume their routine contraceptive method in respect to UPA administration. Patients should be advised to discontinue their current contraceptive method (if able) for 5 days following UPA administration, and should abstain or use condoms during this period and for 7 days after starting or restarting the patient’s usual hormonal contraceptive method. If the patient accepts UPA, after counseling on interactions, but cannot or chooses not to stop their current hormonal contraceptive method, they should abstain or use condoms for 12 days following UPA administration.
- A regular hormonal contraception method can be initiated or resumed immediately after taking progestin-only EC or combined OCPs.

**MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM
PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY
DEPARTMENT CLINICIANS**

- Patient should be instructed to contact a medical provider immediately if they vomit within 2-3 hours of oral EC administration. A repeat dose may be advised.
- Upon request, contact Planned Parenthood Patient Navigation line at 617-616-1636 for assistance scheduling timely Copper T IUD insertion following sexual assault. A supportive referral for IUD insertion may also be provided to a nearby MDPH Family Planning Program by contacting 617-624-6060 or visiting www.mass.gov/emergencycontraception.
- The MDPH Family Planning Program, Health Safety Net Confidential, and/or Victim's Crime Compensation application may be used to fully reimburse the cost of IUD insertion and removal for survivors of sexual assault.
- Encourage the patient to contact their primary care provider, women's health provider, or family planning clinic for follow-up and to discuss birth control and STI/HIV prevention.