SHORT COMMUNICATION

Postabortion contraception

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Abstract

The European Society of Contraception Expert Group on Abortion identified as one of its priorities to disseminate up-to-date evidence-based information on postabortion contraception to healthcare providers. A concise communication was produced which summarises the latest research in an easy-to-read format suitable for busy clinicians. Information about individual methods is presented in boxes for ease of reference.

Explanation

This short communication explains the recommended timing of starting reversible contraceptive methods after abortion. All women should receive information about and be offered a supply of contraception, including emergency contraception, before leaving a healthcare facility(1). It is safe to initiate contraception immediately after abortion; all contraceptive options may be chosen from, unless there are medical restrictions for an individual woman(2).

Ideally, contraception should be offered and provided on the same day and in the same place as the abortion procedure. For women undergoing early medical abortion it may be more convenient to initiate their method at the time of mifepristone administration; this timing is not possible or optimal for all methods. If the contraceptive method chosen by the woman cannot be provided on-site, the woman should be given information about where and how she can obtain it, and be offered an interim method(1).

Individual contraceptive methods are covered in the seven boxes below. During counselling, women should be made aware that long-acting reversible contraceptive (LARC) methods are in a higher tier of effectiveness and that further pregnancies are less likely than when shorter acting methods are used.

Individual methods

Intrauterine contraception

IUCs should be inserted at the time of surgical abortion or as soon as expulsion has been confirmed after medical abortion(3). It is not necessary to wait for four weeks after the abortion; indeed, doing so is associated with a higher rate of subsequent pregnancy(3). There is no correlation between endometrial thickness and IUC expulsion(4).

Implants

Implants can be inserted at the time of surgical abortion. For women undergoing early medical abortion, insertion of etonogestrel implants on the day of mifepristone administration has been shown not to interfere with the effectiveness of the medical abortion(5, 6); such timing also reduces the risk of subsequent pregnancy compared with insertion at a later follow-up consultation(6).

Injectables

Injectable methods (intramuscular and subcutaneous) can be initiated on the day of surgical abortion or, for women undergoing medical abortion, on the day of misoprostol administration. If intramuscular depot medroxyprogesterone acetate is given on the same day as the mifepristone, the effectiveness of the medical abortion may be impaired(7).

Other hormonal methods

Oral contraception and transdermal patches may be initiated immediately after an abortion. Evidence on postabortal use of the vaginal ring is sparse; if bleeding is heavy insertion of the ring can be delayed for up to five days after the abortion.

Barrier methods

Female barrier methods can be initiated as soon as required after a first-trimester abortion. The diaphragm and cap are unsuitable until six weeks after a second-trimester abortion(2).

Fertility awareness methods

These cannot be used until the menstrual cycle has resumed.

Emergency contraception

EC pills should be offered at unprotected sex from five days after an abortion(8). A copper IUD can be inserted as soon as the uterus is empty.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

References

1. Safe abortion: technical and policy guidance for health systems. 2nd ed. Geneva: World Health Organization; 2012.

2. Medical eligibility for contraceptive use. 5th ed. Geneva: World Health Organization; 2015.

3. Gemzell-Danielsson K, Kopp Kallner H, Faúndes A. Contraception following abortion and the treatment of incomplete abortion. Int J Gynecol Obstet. 2014;126:S52-5.

4. Sääv I, Stephanson O, Gemzell-Danielsson K. Early versus delayed insertion of intrauterine contraception after medical abortion - a randomized controlled trial. PLoS ONE. 2012;7:e48948.

5. Raymond EG, Weaver MA, Tan Y, Louie KS, Bousiéguez M, Lugo-Hernández EM, et al. Effect of immediate compared with delayed insertion of etonogestrel implants on medical abortion efficacy and repeat pregancy. Obstet Gynecol. 2016;127:306-12.

6. Hognert H, Kopp Kallner H, Cameron S, Nyrelli C, Jawad I, Heller R, et al. Immediate versus delayed insertion of an etonogestrel releasing implant at medical abortion - a randomized controlled equivalence trial. Human Reproduction. 2016;31:2484-90.

7. Raymond EG, Weaver MA, Louie KS, Tan Y, Bousiéguez M, Aranguré-Peraza AG, et al. Effects of depot medroxyprogesterone acetate injection timing on medical abortion efficacy and repeat pregnancy. Obstet Gynecol. 2016;128:739-45.

8. Clinical Effectiveness Unit. Contraception after pregnancy. London: Faculty of Sexual & Reproductive Healthcare; 2017.