9. Pregnancy Risk Evaluation and Care

Recommendations at a glance to evaluate and treat pregnancy:

- Discuss the probability of pregnancy with patients with reproductive capability.
- Administer a pregnancy test for all patients with reproductive capability (with their consent).
- Discuss treatment options with patients in their preferred language.
- A victim of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent and consistent with current treatment guidelines. Conscience statutes will continue to protect health care providers who have moral or religious objections to providing certain forms of contraception. In a case in which a provider refuses to offer certain forms of contraception for moral or religious reasons, victims of sexual assault must receive information on how to access these services in a timely fashion.

Becoming pregnant from a sexual assault is a significant concern of sexual assault patients, and patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment options. Most programs offer pregnancy prevention or interception for sexual assault patients if they are seen within 120 hours of the assault. Examiners and other involved health care personnel must be careful not to influence patients' choices of treatment.

Discuss the probability of pregnancy with patients with reproductive capability. The risk of pregnancy from sexual assault is estimated to be 2 to 5 percent, similar to the risk of pregnancy from a one-time sexual encounter. The 2005 National Crime Victimization Study [287] reported 64,080 female victims of rape; therefore, statistically speaking, up to 3,204 pregnancies could have resulted from the rapes. Any female of reproductive capability (Tanner Stage 3 and above, irrespective of menarche) can potentially become pregnant from any single exposure. Determination of the probability of conception also depends upon other variables, for example, the use of contraceptives, regularity of the menstrual cycle, fertility of the victim and the perpetrator, time in the cycle of exposure, and whether the perpetrator ejaculated intravaginally. Pregnancy resulting from sexual assault often is a cause of great concern and significant additional trauma to the victim, so victims' fears should be taken seriously.[288] Although many transgender male individuals believe they are infertile as a result of using testosterone, cases have been reported of unexpected pregnancies. Therefore, if a transgender male individual has not had a hysterectomy, is still within childbearing years, and the nature of the assault suggests it, the possibility of pregnancy should be discussed, even if he has not been menstruating.

Administer a pregnancy test for all patients with reproductive capability (with their consent).[289] An exception is if a patient clearly is pregnant. If a patient is pregnant, the pregnancy may affect what medications can be administered or prescribed in the course of or after the exam. Follow policies of the medical facility for pregnancy testing. Sensitive beta-HCG pregnancy tests can be utilized. Most commercially available urine pregnancy tests are sensitive to about 50 milli-international units/ml and will detect pregnancy 8 to 9 days after conception, before a menstrual period is missed. Blood pregnancy tests will detect HCG at very low levels. If the pregnancy test is positive, emergency contraception is contraindicated and decisions about other medications (e.g., STI prophylaxis) must be made in consideration of the pregnancy. If the test is negative and the patient has had unprotected intercourse within the last 10 days and would continue that pregnancy if conception has occurred, then she may be considered to be pregnant and emergency contraception would not be administered.

Discuss treatment options with patients in their preferred language, including emergency contraception.[290] In cases of sexual assault, pregnancy is often an overwhelming and genuine fear. Therefore, discuss treatment options with patients, including emergency contraception. An immediate option

[287] Bureau of Justice Statistics Bulletin, 9/2005 NCJ 214644.
[288] L. Ledray, *SANE Development and Operation Guide*, 2000, p. 75.
[289] Preexisting pregnancy may raise patient privacy issues. If the case is prosecuted, the prosecutor should work to address concerns such as this one.
[290] The National Sexual Violence Resource Center (877–739–3895 or 717–909–0710) offers more detailed information about sexual assault and pregnancy on their Web site at http://www.nsvrc.org/.

is to offer hormone therapy (emergency contraception pills or EC).[291] Another option is to forgo immediate treatment and have the patient follow-up with their primary care provider. Discuss options with the patient and information regarding the timeframe for emergency contraception provision, so she can make an informed decision. Inform the patient that the provision of any emergency contraception will not prevent sexually transmitted infections. The conversation with the patient should include a thorough discussion, including mechanism of action for each treatment option, side effects, dosing, and follow-up. This information should also be provided in writing in the preferred language of the patient, if possible.

A victim of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent and consistent with current treatment guidelines. Conscience statutes will continue to protect health care providers who have moral or religious objections to providing certain forms of contraception. In a case in which a provider refuses to offer certain forms of contraception for moral or religious reasons, victims of sexual assault must receive information on how to access these services in a timely fashion.

Offer/provide the patient with emergency contraception pills and anti-nausea medication if they are at risk, according to facility policy.[292] Emergency contraception is a hormonal method of preventing pregnancy that can be used after sexual assault. There are multiple products available for EC. It is recommended, however, that levonorgestrel,[293] a synthetic hormone,[294] be used.[295] This option is recommended for its higher efficacy rate and ease of dosing, and the fewest number of side effects, particularly nausea and vomiting.[296] Levonorgestrel will not end a pregnancy that is already in progress and is considered a safe and easy treatment for victims of assault in preventing a pregnancy. Levonorgestrel is *most* effective if used within 120 hours and can reduce the risk of pregnancy by up to 89 percent.[297] Traditional dosing of levonorgestrel includes administering two doses of 0.75 mg taken orally 12 hours apart. However, some studies indicate that single dosing with 1.5 mgs of levonorgestral are just as effective and better tolerated by the patient.[298]

Follow-up Care: The patient should be informed that following the use of EC, there may be a heavier or lighter menses than usual and the menses onset may not occur at the expected time. If no bleeding has occurred within three weeks, the patient should be reevaluated and a repeat pregnancy test performed. The patient must be advised not to have unprotected intercourse until after the menses has occurred, or the repeat pregnancy test is negative.

If the facility chooses not to provide EC on site, the patient should be given prescriptions for EC and antinausea medications, with a list of pharmacies that stock the medication. [299]

If the facility is not willing to provide EC or write the needed prescriptions, it is recommended that the patient be given local referrals to medical facilities that can *immediately* assist with alternative treatment.

If no referral is available, provide the patient with the following phone numbers: 1-888-not2late or the online reference: http://not-2-late.com.[300]

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[291] Copper Bearing Intra-Uterine Devices (IUDs) may also be an option, however, they are much less recommended because of the risk of infection in certain cases, the potentially painful insertion procedure, and the need for follow-up care.
[292] CA Protocol
[293] Task Force on Postovulatory Methods of Fertility Regulation. Randomized controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet*. 1998;352:428-433.
[294] FDA website: http://www.fda.gov/cder/drug/infopage/planB/planBQandA.htm.
[295] Relative contraindications for birth control, caution must be exercised when providing any EC with estrogen. Plan B does not contain estrogen, but contraindications should still be noted. The only absolute contraindication for the use of Plan B is preexisting pregnancy.
[296] H.B. Croxatto, L. Devoto, M. Durand, E. Ezcurra, F. Larrea, C. Nagle, et al. Mechanism of Action of Hormonal Preparations Used for Emergency Contraception; a Review of the Literature. *Contraception.* 2001: 63:111-121
[297] http://www.planbonestep.com/plan-b-prescribers/index.aspx
[298] Alternative dosing for Plan B includes administering the tablets together in a one time dose. A study done by WHO found that the effectiveness of administering single doses of levonorgestral was as effective as administering the doses 12 hours apart. Helena von Hertzen, Gilda Piaggio, Juhong Ding et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial. The Lancet: December 7, 2002: Vol 360 (9348):1803-10.
[299] J.S. Gardner, J. Hutchings, T.S. Fuller, D. Downing. Increasing access to emergency contraception through community pharmacies: lessons from Washington state. *Family Planning Perspective. 2001;33(4):142-175.*
[300] This hotline and website are operated by the Office of Population Research at Princeton University and by the Association for Reproductive Health Professionals.