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Šprem Goldštajn, Marina; Pavičić Baldani, Dinka; Škrgatić, Lana;
Radaković, Branko; Vrčić, Hrvoje; Čanić, Tomislav

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Ulipristal Acetate in Emergency Contraception

Marina Šprem Goldštajn, Dinka Pavičić Baldani, Lana Škrgečić, Branko Radaković,
Hrvoje Vrčić and Tomislav Čanić

University of Zagreb, School of Medicine, University Hospital Center Zagreb, Department of Obstetrics and Gynecology,
Division of Human Reproduction, Zagreb, Croatia

ABSTRACT

Despite the widespread availability of highly effective methods of contraception, unintended pregnancy is common. Unplanned pregnancies have been linked to a range of health, social and economic consequences. Emergency contraception reduces risk of pregnancy after unprotected intercourse, and represents an opportunity to decrease number of unplanned pregnancies and abortions. Emergency contraception pills (ECP) prevent pregnancy by delaying or inhibiting ovulation, without interfering with post fertilization events. If pregnancy has already occurred, ECPs will not be effective, therefore ECPs are not abortifacants. Ulipristal acetate (17 α -acetoxy-11 β -(4N-N,N-dimethylaminophenyl)-19-norpregna-4,9-diene-3,20-dione) is the first drug that was specifically developed and licensed for use as an emergency contraceptive. It is an orally active, synthetic, selective progesterone modulator that acts by binding with high affinity to the human progesterone receptor where it has both antagonist and partial agonist effects. It is a new molecular entity and the first compound in a new pharmacological class defined by the pristan stem. Up on the superior clinical efficacy evidence, UPA has been quickly recognized as the most effective emergency contraceptive pill, and recently recommended as the first prescription choice for all women regardless of the age and timing after intercourse. This article provides literature review of UPA and its role in emergency contraception.

Key words: emergency contraception, ulipristal acetate

Introduction

Despite the widespread availability of highly effective methods of contraception, unintended pregnancy is common. In both US and EU it is estimated that about half of all pregnancies are unplanned^{1,2}. Situation in Croatia is estimated to be similarly unsatisfactory³. More than half of unwanted pregnancies – an estimated 45.5. million worldwide – are resolved by induced abortion each year⁴. Unplanned pregnancies have been linked to a range of health, social and economic consequences¹.

Emergency contraception (EC) is defined as the use of any drug or device used after an unprotected sexual intercourse or contraceptive method failure to prevent an unwanted pregnancy⁵. It is an occasional contraception method and should not replace regular contraception. EC significantly reduces the risk of unintended pregnancy after the sexual intercourse⁶⁻⁸. It has been estimated that millions of unintended pregnancies could be avoided if effective EC were widely accessible⁹. While interventions to make EC available have clearly failed in reducing abortion rates¹⁰, it has been well recognized

that EC is underused worldwide. In order to benefit from lessons learned and to secure positive population impacts from introducing dedicated ECPs in Croatia, EC methods and policies have been recently evaluated and four actionable points were recognized¹¹.

Methods used postcoitally included estrogen only regimen, combination of estrogen and levonorgestrel (LNG), LNG only, mifepristone and insertion of a copper intrauterine device (IUD)⁶. Recently, a new class of progesterone receptor modulator ulipristal acetate has been introduced⁶. Up on the superior clinical efficacy evidence, UPA has been quickly recognized as the most effective ECP^{6,7} and recently recommended as the first choice ECP¹² for all women regardless of the age and timing after intercourse. UPA is considered to be a pluripotent molecule, already confirmed to be effective in preoperative treatment of uterine fibroids^{13,14} and intensively investigated in various different indications¹⁵.

Objective of this paper is to provide overview on UPA and its role in EC.

Emergency Contraception

Following unprotected sexual intercourse, pregnancy is likely to result only during the fertile period that extends from 5 days before ovulation to the day of ovulation¹⁶. Once released, oocyte deteriorates rapidly to a point where fertilization is unlikely. During this fertile period probability of conception varies. In estimating the need for emergency contraception after the unprotected intercourse, it is important to consider variability of the ovulation, and major discrepancy observed between women's self-report of stage of a menstrual cycle and the dating calculation based on endocrine data¹⁷. As it is difficult to accurately predict the exact stage of the menstrual cycle at which unprotected intercourse occurred, emergency contraception is generally indicated at any time of the cycle^{6–8}.

Yuzpe method was introduced in late 1970s, and consisted of 200 mcg ethinyl estradiol and 1000 mcg levonorgestrel divided in two doses, and given within 72 h after the intercourse¹⁸. It has remained the standard hormonal EC method until the introduction of LNG only and mifepristone regimens^{19,20}. LNG only regimen is more effective and causes fewer side effects compared to the Yuzpe regimen¹⁹. It is to be given in a single 1.500 mcg dose within 72 hours after the intercourse. Its key limitation is decrease in efficacy over the time after the intercourse, as well as inability to prevent ovulation once the LH surge has started^{19–23}. Mifepristone is effective and well tolerated in EC, but for social and political reasons it is available for EC only in Russia and China^{16,24}. UPA is the first drug that was specifically developed and licensed for use as an emergency contraceptive. It is to be given in a single 30 mg dose, within 120 h after the intercourse.

A major barrier to the widespread acceptability and use of EC is concern regarding mechanisms of action of EC methods. The best available evidence indicates that emergency contraception pills (ECP) prevent pregnancy by delaying or inhibiting ovulation^{6–8,16,23} therefore ECPS do not seem to interfere with postfertilization events. Endometrial effects of ECP do not contribute to their efficacy in EC. If pregnancy has already occurred, ECPs will not be effective, therefore ECPs are not abortifacients^{6–8,12}. When IUD is used as a regular or emergency method of contraception, it acts primarily to prevent fertilization. EC insertion of a copper IUD is significantly more effective than use of ECPs, reducing the risk of pregnancy by more than 99.9%^{8,25}. Such a high level of effectiveness implies that emergency insertion of a copper IUD might prevent some pregnancies after fertilization⁶.

The EC should be taken as early as possible but no later than 120 hours for IUD and UPA, and no later than 72 hours for LNG. Inserting IUD for emergency contraception has the advantage of providing further contraception, while all ECP users need to use additional barrier methods till end of the cycle during which they took ECP⁶.

UPA – Structure

The development of molecules with specific steroid antagonist properties holds great promise for a variety of therapeutic applications. Ulipristal acetate (17 α -acetoxy-11 β -(4N-N,N-dimethylaminophenyl)-19-norpregna-4,9-diene-3,20-dione) was first synthesized by Research Triangle Institute under a contract with the National Institute of Child Health and Human Development (NICHD) for the development of new compounds that exhibit selective inhibition of the progesterone receptor with minimal effect on other steroid receptors. It is therefore a new molecular entity and the first compound in a new pharmacological class defined by the pristan stem. Its hormonal and antihormonal activity, selectivity and potency of its proximal metabolites were thoroughly evaluated^{26,27}.

UPA – Pharmacodynamics

UPA is an orally active, synthetic, selective progesterone modulator that acts by binding with high affinity to the human progesterone receptor^{28,29}, where it has both antagonist and partial agonist effects²¹. The drug has minimal affinity for the androgen receptor and no affinity for the human estrogen or mineralocorticoid receptors²⁹. Although UPA has demonstrated some affinity for glucocorticoid receptor in animals, no antiglucocorticoid effects have been observed in humans. Moreover, its glucocorticoid receptor antagonist activity is much reduced compared to that of mifepristone²⁷ indicating that ulipristal acetate belongs to a new class of progesterone receptor modulators with dissociated glucocorticoid activity.

The key UPA mechanism of action in emergency contraception is to inhibit or to delay ovulation, although it is not fully clear by which mechanism this occurs^{23,26–29}. A series of clinical pharmacodynamics studies found that when administered at a point in the menstrual cycle prior to the onset of the LH surge, or before the peak in LH level had been reached, UPA significantly delays the LH peak by at least five days. When administered prior to the LH peak, UPA significantly delayed follicular rupture³¹. In a placebo controlled study in women with normal menstrual cycles, single doses of UPA 10, 50, 100 mg administered at the mid follicular stage with the follicle diameter of 14–16 mm significantly suppressed lead follicle growth, which lead to a dose dependent delay in folliculogenesis and plasma estradiol levels suppression³¹. Double blind crossover randomized placebo controlled study demonstrated that a single UPA dose of 30 mg given immediately prior ovulation significantly delayed follicular rupture even in women in whom LH surge has already commenced²³. This indicates that UPA is effective during a longer period compared to LNG, which needs to be administered before the onset of LH surge in order to effectively prevent pregnancy²². However it is important to recognize that if UPA is administered after the LH peak being reached, follicular rupture

is not delayed²³. Animal studies indicate that UPA may have a direct inhibitory effect on follicular rupture³⁰.

Endometrial effects of UPA were shown to be dose dependent. Following a single UPA dose of 10, 50 and 100 mg given in the early luteal phase and within 2 days of LH surge, endometrial thickness was reduced in a dose dependent manner with statistic difference, for all doses combined and *vs.* placebo³². The decrease between 10 and 50 mg appeared to be minimal. In addition to this, alterations in progesterone dependent markers of implantation also were observed in endometrial glandular epithelium³².

UPA had a dose dependent effect on menses when administered in mid luteal phase. Higher doses (100–200 mg) were associated with earlier menses (33 ADIS 20). Clinical trials have showed that a cycle length was increases by a mean of 2.5 days. There was no indicator of cycle length being influenced by the time of the menstrual cycle in which UPA was given (34 ADIS 21).

UPA – Pharmacokinetics

In a study of 20 women under fasting conditions following the administration of a single 30 mg oral dose, UPA was demonstrated to be rapidly absorbed. It reached mean peak plasma concentrations (C_{max}) of the drug and its major active metabolite mono-demethylated ulipristal acetate of 176 ng/mL and 69 ng/mL respectively at 0.9 and 1.0 hours^{28,29}. Corresponding values for the area under the plasma concentration-time curve from time zero to infinity AUC were 556 and 246 ng h/mL.

A high fat meal reduces mean C_{max} by –45%, and delays t_{max} from a median of 0.75 hours to 3 hours, and mean AUC is increased by 24% compared with the administration in the fasting state^{28,29}. Similar was observed with the main metabolite. In despite of this finding, phase III trials have not demonstrated any effects of concomitant food intake and UPA efficacy³⁵.

UPA is highly bound to plasma proteins (>94%) albumin, alpha-1-acid-glycoprotein and high density lipoprotein^{28,29}. Following ingestion, UPA is intensively metabolized in the liver to mono-demethylated metabolites of which only the mono-demethylated metabolite is pharmacologically active. In vitro studies show that metabolism is predominantly mediated by cytochrome P450 (CYP)3A4 enzymes, and to a lesser extent by CYP1A2 and CYP2D6^{28,29}.

Excretion of UPA is primarily via the feces. After a single dose of 30 mg micronized UPA, 32 hours is the estimated terminal elimination plasma half-life for UPA, and 27 for mono-demethylated-ulipristal acetate^{28,29}.

No differences have been observed between women of different ethnic groups in clinical studies^{25,26}. Pharmacokinetic studies in women with renal impairment or in women aged <16 years have not been performed. Repeated UPA doses in animal studies resulted in some embryo-fetal loss, but at doses low enough to maintain gestation, no indication of any teratogenic potential has

been detected^{28,29}. As for any new molecular entity, the sum of information on the impact of exposure to UPA in early pregnancy remains limited, however currently raising no concern. An online registry has been established in order to facilitate the collection of information on pregnancies that were exposed to UPA in the early stages of pregnancy.

Drug interaction studies have not been performed with UPA. Having in mind major CYP3A4 metabolism pathway, interactions are possible when co-administered with agents that induce or inhibit CYP3A4^{28,29}. Therefore, co-administration of CYP3A4 inducers (rifampicin, phenitoin, phenobarbital, long term use of ritonavir, ECP containing levonorgestrel) or agents that increase gastric pH is not recommended as plasma concentrations of UPA may be decreased leading to a loss of efficacy.

Having in mind UPA's affinity for progesterone receptor, it could interfere with progesterone actions. Although the use of UPA is not contraindicated to the continued use of regular hormonal contraception, it is possible that the contraceptive action of combined hormonal contraceptives (CHC) and progesterone only contraceptives (POC) may be reduced²⁹.

UPA – Efficacy

The effectiveness of a preventive therapy is best measured by comparing probability that the condition will occur if the therapy is used to the probability that it will occur without treatment. For majority of preventive therapies effectiveness is determined by randomized clinical trials comparing treatment to placebo. In the case of emergency contraception placebo controlled trials are considered to be non ethical. Initial EC efficacy was demonstrated in noncomparative observational trials. Therefore, the chance that pregnancy would occur in the absence of EC is estimated indirectly using published data on probability of pregnancy on the each day of the menstrual cycle^{38,39}. The estimate is compared with the actual number of pregnancies observed after treatment in observational treatment trials. EC effectiveness calculation obviously involves many assumptions that are hard to validate.

The efficacy of UPA has been evaluated during phase II and III clinical research: one phase II trial³⁴ and two phase III^{38,39} multicentre trials in women requesting emergency contraception following unprotected sexual intercourse. Two trials were randomized, single³⁵ or double³⁴ blind non-inferiority trials that compared pregnancy rates between UPA and LNG. The third open label study³⁹ compared pregnancy rates between UPA and those estimated in the absence of EC. Two randomized trials compared the efficacy of UPA and LNG, one up to 72 hours after sexual intercourse³⁴, and the other up to 120 hours after the intercourse³⁸. When these two studies of a similar design were combined in a meta-analysis, UPA was found to have 42% lower pregnancy rate than LNG within 72 hours after the intercourse: in the LNG treatment group (N=1625) there were 35 pregnancies,

while in UPA treatment group (N= 1617) there were 22 pregnancies³⁸. Even more important, within 24 hours after the intercourse, during the day of the best LNG efficacy, UPA was found to have 65% lower pregnancy rate than LNG: in LNG treatment group (N=600) there were 15 pregnancies, while in UPA group (N=584) there were 5 pregnancies³⁸. In the open label trial, the pregnancy rate in patients receiving UPA within 48–120 hours from unprotected sexual intercourse was significantly lower than that of expected pregnancy rate in the absence of emergency contraception³⁹. This study delivered another important learning, that unlike LNG, UPA has demonstrates sustained efficacy when administered at any time between 48–120 hours from unprotected intercourse³⁹.

Rational behind significantly lower pregnancy rates on UPA when compared to LNG seems to be higher UPA efficacy in postponing imminent ovulation as LNG is no more effective than placebo in preventing ovulation after the onset of the LH surge, and after the follicular diameter has reached 15–17 mm. On the contrary, UPA can effectively delay ovulation even after the onset of the LH surge (till it reaches its peak concentration), and follicular diameter reached 18–20 mm. Additional efficacy related advantage of UPA is sustained efficacy through 120 hours from unprotected sexual intercourse.

UPA – Tolerability and Safety

In all trials UPA was generally well tolerated, with majority of side effects being mild to moderate in severity and resolving spontaneously in 89–94%. Tolerability of UPA seems to be comparable to LNG^{34,38,39}.

The most frequently reported UPA treatment related adverse effects were headache, nausea, dysmenorrhea and abdominal pain, a profile similar to that reported in LNG comparative groups.

In an open label phase II study the most frequently reported treatment related adverse effects (AE) of UPA were headache (9.3%), nausea (9.2%) and abdominal pain (6.8%)³⁹. Other AE reported in this study were dysmenorrhoea (4.15%), dizziness (3.5%) and fatigue (3.4%).

In another phase III study UPA was demonstrated to be as well tolerated as LNG³⁵. The most common adverse events in UPA and LNG treatment groups were headache (19% vs. 18.5%) nausea (13% vs. 11.5%), dysmenorrhoea (13% vs. 14.5%), fatigue (5.5% vs. 4%) and abdominal pain (5% vs. 6.5%)³⁸.

UPA was generally associated with delayed onset of menses^{31,35,36}. Mean menstrual cycle length increased by 2.1³⁸, 2.6³¹ and 2.8³⁹ days in UPA groups, while the onset of menses was a mean of 1.2³⁸ and 2.1³⁴ days earlier in LNG groups.

UPA has not affected the duration of bleeding³⁸.

Intermenstrual bleedings with UPA in most cases were described as spotting and were reported by 8.7% of women compared of 3.3% before enrolment³⁹.

There were no changes of clinical significance in complete blood count, hepatic and renal function, lipids and random glucose analysis in 100 women monitored before and after UPA treatment³⁶.

There are no medical contraindications to the use of combined or progestin only ECPs with the exception of pregnancy^{6–8,12}. UPA is a novel chemical entity and is contraindicated in existing or suspected pregnancy²⁹. As for any new molecular entity, the sum of information on the impact of exposure to UPA in early pregnancy remains limited and currently raising no concern^{6–8,12,29}. Although no teratogenic potential was observed, animal data are insufficient with regard to reproduction toxicity²⁹. Therefore, a pregnancy registry has been established in order to facilitate the collection of information on pregnancies in EU that were exposed to UPA in early stages of pregnancy, allowing further investigation²⁹. The key reason ECP should not be used in pregnancy is not because they are harmful but because they are ineffective⁶.

UPA is lipophilic compound and therefore excreted in the human milk. Risk to the breast-fed child cannot be excluded. After the intake of UPA, breastfeeding should be discontinued for a week. During this time it is recommended to express and discard the milk in order to stimulate lactation²⁹.

A rapid return of fertility is likely following UPA treatment, therefore continuing or initiating regular contraception is recommended as soon as possible²⁹.

Conclusion

UPA is the first of a new class selective progesterone receptor modulators that acts by binding with high affinity to the human progesterone receptor where it has both antagonist and partial agonist effects. It is the first entity specifically developed for EC, but it is also intensively investigated in other indications. UPA provides effective, sustained and well tolerated emergency contraception when taken within 120 hours after unprotected intercourse or contraceptive failure. Before prescribing UPA and all other ECPs pregnancy must be excluded, usually by reviewing dates and the nature of the last period. Unlike LNG, UPA is able to prevent follicular rupture and to potentially prevent pregnancy even when given in advanced follicular stage of the menstrual cycle and thus provides a longer treatment window than LNG. Because of superior efficacy within 24 hours, 72 hours and 120 hours from unprotected intercourse when compared to LNG, UPA is recognized as the most effective ECP, and recently recommended as the first prescription choice for all women regardless of the age and timing after intercourse.

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M. Šprem-Goldštajn

University of Zagreb, School of Medicine, University Hospital Center Zagreb, Department of Obstetrics and Gynecology, Division of Human Reproduction, Petrova 13, 10000 Zagreb, Croatia
e-mail: marina.goldstajn@gmail.com

ULIPRISTAT ACETAT U HITNOJ KONTRACENCIJI

SAŽETAK

Unatoč dostupnosti vrlo učinkovitih metoda kontracepcije, učestalost neželjenih trudnoća vrlo je visoka. Neplanirane trudnoće dovode do niza zdravstvenih rizika, te nose socijalne i ekonomske posljedice. Hitna kontracepcija umanjuje rizik od trudnoće nakon nezaštićenog spolnog odnosa, i predstavlja mogućnost za smanjenje broja neplaniranih trudnoća i pobačaja. Pilule za hitnu kontracepciju (eng. emergency contraceptive pill, ECP) sprječavaju trudnoću odgađajući ili inhibirajući ovulaciju, bez interferencije sa postfertilizacijskim procesom. Ukoliko je do trudnoće već došlo, ECP neće biti učinkovita. Stoga se ECP ne smatraju abortivnim sredstvima. Ulipristal acetat (UPA) (17 α -acetoksi-

-11 β -(4N-N, N-dymethylaminophenyl)-19-norpregna-4,9-dien-3,20-dion) je prvi lijek koji je posebno razvijen i licenciran za upotrebu kao hitni kontraceptiv. Ulipristal acetat je oralno aktivni, sintetički, selektivni modulator progesteronskih receptora koji djeluje vežući se s visokim afinitetom za humani receptor za progesteron. Posjeduje i antagonističke i parcijalno agonističke učinke. Ulipristal acetat se smatra novim molekularnim entitetom i prvom komponentom farmakološke klase definirane kao pristalna osnova. S obzirom na dokazan klinički superioran učinak, UPA je brzo poznat kao najučinkovitije sredstvo za hitnu kontracepciju, te je nedavno preporučeno kao lijek prvog izbora za sve žene bez obzira na dob. Ovaj članak daje pregled literature o UPA i njegovoj ulozi u hitnoj kontracepciji.