Straight to the Point: Talking IUC

Step-by-step guidance to addressing concerns with intrauterine contraception
The INTRA group

**INTRA group**: Intrauterine contraception: Translating Research into Action

- A panel of independent physicians with expert interest in intrauterine contraception
- **Purpose**: To encourage more widespread use of IUC methods in a broad range of women through medical education

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Despite the availability of an extensive range of contraceptive options, a high number of pregnancies are unplanned. IUC is a highly effective method of contraception. In 95% of women it can be placed easily and successfully, and risk of complications is low. However, concerns around placement and potential complications prevent some HCPs from recommending IUC. The INTRA group provides step-by-step guidance to address these concerns. For help in addressing your particular concern, click on the appropriate icon.
Difficult placement

- Perforation at time of insertion (with sound)
- Return for placement with ultrasound (in 2-3 weeks if patient still motivated to use IUC)
- Failed attempt
- Severe pain

Counsel and reassure patient extensively for another attempt at placement

Pain

Ultrasound guidance
- Ensure no creation of false passage
- Metal sound easy to see on abdominal ultrasound in non-obese women
- A low position in the uterus i.e. not at the fundus, is not generally a concern (as long it is not in the cervical canal) but back-up contraception and a re-scan in 2-4 weeks to check if migrated into optimal position may provide reassurance

Misoprostol
- Place during menses

Mechanical help
- Os finder or cytobrush
- Sterilized or one way Hegar (or Pipelle) to identify path of endocervical canal
- Adequate traction with tenaculum
- Repositioning of tenaculum (to get round ‘kinks’ or ‘lip’ in cervical canal)
- Small 5 mm Denniston dilator to achieve greater dilation

Correlate bimanual exam with uterus sounding

Failed attempt

Perforation at time of insertion (with sound)

Return for placement with ultrasound (in 2-3 weeks if patient still motivated to use IUC)

Counsel and reassure patient extensively for another attempt at placement

Pain

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**Ease of insertion: myth versus reality**

- **Myth**: It is very difficult/impossible to insert IUC in nulliparous women
- **Reality**: In the vast majority of women, IUC is inserted with ease regardless of parity

<table>
<thead>
<tr>
<th>Reference</th>
<th>Country</th>
<th>Sample size and composition</th>
<th>% of LNG-IUS placements rated as ‘easy’</th>
<th>% of successful LNG-IUS placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marions et al, 2011⁴</td>
<td>Sweden</td>
<td>224 nulliparous women</td>
<td>72%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Suhonen et al, 2004⁵</td>
<td>Finland and Sweden</td>
<td>94 nulliparous women</td>
<td>85%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Bahamondes et al, 2011⁶</td>
<td>Brazil</td>
<td>159 nulligravid women</td>
<td>81%</td>
<td>99.4%</td>
</tr>
</tbody>
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**Reference Country Sample size and composition**

- Marions et al, 2011⁴ Sweden 224 nulliparous women
- Suhonen et al, 2004⁵ Finland and Sweden 94 nulliparous women
- Bahamondes et al, 2011⁶ Brazil 159 nulligravid women

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**No threads visible**

- Use cytobrush to retrieve threads
- Palpate

**Unable to confirm IUC with cytobrush**

- Immediate access to ultrasound

**Able to confirm IUC**

- Low position in uterus
- Position at the fundus
- Remove if embedded in myometrium
- Reassure

**If Cu-IUD:**
- Counsel patient on pregnancy risk if Cu-IUD does not move into position
- Check position at 3 months if needed

**If LNG-IUS:**
- Reassure patient that the low position will not impact on efficacy

If patient requests IUC removal:
- Use cytobrush, palpation, IUS hook, and packing forceps

**If patient requests IUC removal:**

- **Able to confirm IUC**
  - Low position in uterus
  - Position at the fundus
  - Remove if embedded in myometrium
  - Reassure

  - If Cu-IUD:
    - Counsel patient on pregnancy risk if Cu-IUD does not move into position
    - Check position at 3 months if needed

  - If LNG-IUS:
    - Reassure patient that the low position will not impact on efficacy

**If LNG-IUS:**

- Counsel patient on pregnancy risk if LNG-IUS does not move into position
- Check position at 3 months if needed

**If patient requests IUC removal:**

- **Unable to confirm IUC with cytobrush or ultrasound and negative pregnancy test**
  - Abdominal/pelvic X-ray (or schedule and counsel on other contraceptive options and consider EC if indicated)
  - IUC in abdomen
  - Recommend surgical management
  - Contraceptive counselling

**If patient requests IUC removal:**

- **No threads visible**
  - No immediate access to ultrasound

- **Negative test**
  - Check pregnancy test
  - Schedule ultrasound
  - Counsel on other contraceptive options and consider EC if indicated

- **Positive test**
  - Immediate access to ultrasound
  - Check pregnancy test
  - Able to confirm IUC
  - Contraceptive counselling

**If patient requests IUC removal:**

- **Unable to confirm IUC**
  - No IUC seen

**If patient requests IUC removal:**

- **Assume expulsion**
  - Abdominal/pelvic X-ray (or schedule and counsel on other contraceptive options and consider EC if indicated)

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Positive test

Obtain ultrasound

Able to confirm intrauterine pregnancy

- Able to confirm position of IUC in uterus
  - Counsel on pregnancy options
    - Continue pregnancy
      - Remove IUC or counsel on increased risk if unable to remove
    - Termination
      - Remove at time of surgical abortion

Unable to confirm intrauterine pregnancy

- Evaluate the possibility of ectopic pregnancy (correlate HCG levels with ultrasound, re-evaluate on 1 week)
  - Intrauterine pregnancy confirmed
  - Ectopic pregnancy confirmed
    - Abdominal/pelvic X-ray (or schedule and counsel on other contraceptive options and consider EC if indicated)

Counsel on pregnancy options

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**Bleeding**

- Irregular bleeding for <6 months since placement AND/OR bleeding less than heaviest period
  - Reassure about bleeding patterns
  - Offer options to manage bleeding if bothersome:
    - Nonsteroidal anti-inflammatories (NSAIDs)/tranexamic acid
    - Estrogen
    - Oral contraceptive pill (OCP)

- Irregular bleeding for ≥6 months since placement OR bleeding more than heaviest period
  - Pregnancy test
  - Gynecological exam

- Before placement, counsel on the expected bleeding pattern

- New episode of heavy bleeding
  - Pregnancy test
  - Gynecological exam
  - Infection
  - Cervical lesion

- Offer options to manage bleeding if bothersome:
  - Nonsteroidal anti-inflammatories (NSAIDs)/tranexamic acid
  - Estrogen
  - Oral contraceptive pill (OCP)

- If continues to be bothersome

- Ultrasound
  - No apparent cause
  - Offer options to manage bleeding:
    - NSAIDS/tranexamic acid
    - Estrogen
    - OCP

- Malposition
  - Consider removal:
    - Counsel on other contraceptive options
    - Consider placement with ultrasound (in 2-3 weeks if patient still motivated to use IUC)

- Treat accordingly

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Please see INTRA Hints and Tips slide set

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Additional information

Amongst adolescent nulliparous and parous women, 20% experience no pain and 70% describe the pain as mild or moderate\textsuperscript{10}
Infection

Asymptomatic

Swab positive for
- Chlamydia trachomatis
- Neisseria gonorrhoea
- Bacterial vaginosis

Swab negative
- No features of PID

Reassure

Follow the antibiotic protocol of the institution

Follow up

Symptomatic

Swab positive
- No features of PID

Consider IUC removal after antibiotics initiated

Clinical PID:
- Sepsis
- Febrile
- Leukocytosis
- Pain

Follow the antibiotic protocol of the institution

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  - Pain

- **Follow up**

- **Follow the antibiotic protocol of the institution**

- **Consider IUC removal after antibiotics initiated**

**Additional information**

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Suspected perforation

Perforation with the sound
- No IUC placement attempt
  - Conservative management and reassurance
  - Consider placement with ultrasound (in 2-3 weeks if patient still motivated to use IUC)

Perforation with the IUC
- Strings visible: Remove immediately
- Strings not visible: Confirm position with pelvic ultrasound or X-ray
  - Able to confirm position
    - Recommend surgical management
      - Consider laparoscopic or hysteroscopic removal
      - Provide contraceptive counselling
  - Unable to confirm position
    - Carry out diagnostic hysteroscopy or diagnostic laparoscopy


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EURAS-IUD shows a low risk of uterine perforation with IUC within the total patient population, incidence of perforation was ~1/1,000 placements.8


**Additional information**

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