SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

STANDARD OPERATING PROCEDURE- GUIDELINE

IMMEDIATE POSTPARTUM IUD INSERTION

SCOPE:

Approximately 70% of pregnancies conceived within the 1st year of delivery are unintended. For women whose contraception goals include preventing short interval pregnancy with a long-acting reversible method, immediate post-partum intrauterine device insertion is a safe and effective means of achieving it. No increase in complications with immediate insertion technique has been identified. Several studies showed slightly higher expulsion rates, with an average of 10% for insertion within 10 minutes of placental delivery **compared with 2% for interval placement**. An increased expulsion rate does not correspond to increased pregnancy rates as most expulsions are recognized by the patient and addressed with insertion of another IUD or initiation of another method of contraception.

Patients who desire IUDs benefit with immediate postpartum insertion even if the expulsion rate is increased. **Women with barriers to accessing contraception postpartum are at higher risk of unintended and short interval pregnancies. Unfortunately,** currently only Medicaid pays for immediate postpartum IUD in New Mexico.

Women who desire an IUD immediately postpartum should be thoroughly counseled regarding the advantages and disadvantages as well as the risks & benefits of the method. There are few *contraindications* to immediate postpartum IUD insertion:

- Untreated STD or treated within the prior month
- Active intrauterine infection (Intra-amniotic infection or inflammation) **and/or sepsis**
- Uterine anomaly incompatible with placement
- Ongoing postpartum hemorrhage
- Retained placenta requiring manual removal

Immediate postpartum insertion of the levonorgestrel IUD is rated MEC Category 2 for women who are breastfeeding, with advantages outweighing potential risks. Although this area of research is limited, overall studies have not illustrated a negative effect on breastfeeding outcomes such as duration of breastfeeding or time to lactogenesis.

PROCEDURES:

Counseling

With reproductive justice principles in mind, counseling should focus on patient autonomy, highlighting patients' contraceptive goals as well as their values and preferences. A post placental IUD may be an optimal choice for a patient desiring LARC contraception, who may not be able to follow up at a clinic for interval placement, and who does not want the implant. Shared decision making is the standard for contraceptive counseling.

- Ideally, contraceptive counseling should occur during antenatal care for a comprehensive discussion of options, risks and benefits
- Patients may opt for an IUD without prior antenatal counseling if they are thoroughly counseled during an inpatient admission when they are not in active labor
- The consent for IUD insertion must be obtained and signed *prior to* delivery.

Nursing

- Bring IUD insertion instrument pack (containing 2 ring forceps and speculum/retractor) and ultrasound to bedside
- Bring sterile gloves for provider
- Bring IUD to delivery table/surgical table
- Bring "surgical" (standard) consent form, signed prior to delivery, into delivery room/OR
- Participate in time-out. Time-out to be performed prior to IUD insertion and RN should verify patient name, MRN and DOB and procedure on the consent form
- Place package insert sticker on consent in chart

Provider

- Provider must be "trained"—i.e., undergone didactic training and 2-3 supervised insertions by current trained attending physicians in OB-GYN, Family Medicine or midwifery
- Lead time out to be performed prior to IUD insertion (Attending must be present for time-out)
- Document counseling of risks/benefits/usage and procedure, including any difficulties with insertion, in procedure note
- Schedule patient for return visit in 2-6 weeks to check for IUD placement and to trim strings.

Technique

Research currently does not support a superior insertion technique. However, our department encourages ACOG's preferred method of ring forceps based placement. More important is the emphasis on performing the same technique with each placement to reduce complications and hopefully decrease risk of expulsion.

Vaginal delivery: 2 physician or physician/nurse technique

- Nurse to bring the pack of instruments in the room every time (2 ring forceps, speculum/retractor)
- Determine patient is still eligible for immediate postpartum IUD
- Time out to be performed prior to the IUD insertion
- Place IUD within 30 minutes postpartum, but OK to place beyond 30 minutes if patient accepts potential increased risk of expulsion
- Break down the bed to facilitate placement

- If the perineal/vaginal area has soiling with stool or meconium then consider a betadine prep.
- Set up IUD for insertion
  - Don new sterile gloves
  - Set up the IUD with a long ratcheted ring forceps to one click, focusing on the arm of the IUD (Liletta/Mirena), arm and stem OK with Paragard
  - Remove IUD from inserter; for Liletta/Mirena, cut strings at about 10 cm, no need to cut strings for Paragard
- Technique
    - Place the posterior blade of a speculum in the vagina and have an assistant hold the blade while you
    - Grasp the anterior cervix with a short ring forceps
    - Guide the IUD into the uterus with left hand on cervix ring forceps and right hand on the IUD ring forceps. After passing the IUD through the cervix, release the hand holding the cervix ring forceps and move it abdominally to palpate the uterine fundus, and to feel the IUD ring forceps within the uterus (this is for right-handed physicians)
    - Release the IUD with ring forceps wide open and remove the ring forceps open wide.

- Note:
    - If you are unable to grasp the cervix with the ring forceps visually, it is OK to try to place it by palpation
    - If you are unable to grasp the cervix with the ring forceps by palpation, it is OK to try to place IUD manually
- Consider use of ultrasound guidance and ultrasound verification of fundal location of IUD.
- A separate string trim visit is generally not needed if the IUD strings are trimmed before placement

Cesarean section
- Time out to be performed prior to the IUD insertion
- Within 20 minutes of placental delivery, place IUD to uterine fundus with inserter or a ring forceps
- Paragard: Don't cut strings
- Mirena: Cut strings to 10 cm BEFORE insertion.
- A separate string trim visit is generally not needed if the IUD strings are trimmed before placement

Document insertion with a note in Powerchart.

IUD string not seen at post-insertion care visit

1. If patient reports known expulsion with visualized IUD then offer appointment for reinsertion at 6 weeks and alternative contraception as bridge

2. If no history of expulsion and unable to identify strings including attempt with cytobrush, then refer to Center For Reproductive Health where patient can have a post-IUD LARC visit including an ultrasound. If not seen on ultrasound, then an x-ray of the abdomen must be done to rule out perforation with intra-abdominal IUD.

REFERENCES:

Lopez LM, Bernholc A, Hubacher D, Stuart G, Van Vliet HAAM. Immediate postpartum insertion of intrauterine device for contraception. *Cochrane Database of Systematic Reviews* 2015, Issue 6. Art. No.: CD003036. DOI: 10.1002/14651858.CD003036.pub3

Committee on Obstetric Practice. Committee Opinion: Immediate Postpartum Long-Acting Reversible Contraception. 2016, Number 670.

Kapp N, Curtis K, Nanda K. Progestogen-only contraceptive use among breastfeeding women: a systematic review. Contraception 2010; 82:17-37.

Jatlaoui TC, Whiteman MK, Jeng G, et al. Intrauterine device expulsion after postpartum placement: A systematic review and meta-analysis. *Obstet Gynecol*. 2018;132(4):895-905. doi:10.1097/AOG.0000000000002822

US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2016

APPROVALS:

SOP Owner:	Gillian Burkhardt, MD	Date: 7/15/20
Chair Approval:		Date: 8/20/20
Effective Date:	August 20, 2020	