Protocol for Post-Placental IUD insertion
July 14, 2010

This Protocol is adapted from the University of Colorado Protocol dated August 26, 2009.

Background

Post-placental intrauterine device (IUD) insertion is a safe, convenient, and effective option for postpartum contraception. “Post-placental” refers to insertion within 10-15 minutes of placental delivery, after vaginal or cesarean delivery.

Compared with other contraceptive methods, early post-partum IUD insertion has several advantages. It provides immediate contraception without interfering with breast feeding, and it may avoid discomfort related to insertion. Inserting an IUD immediately after placental removal has not been associated with increased infection, uterine perforation, postpartum bleeding, or uterine subinvolution (1, 2). The expulsion rate is higher (approximately 12% in the first postpartum year) after immediate postpartum insertion compared to insertion 4 to 8 weeks later. Continuation rates are relatively high (87.6% and 76.3%, at 6 and 12 months, respectively) (3).

For women with limited access to medical care, term delivery provides an important opportunity to address the need for contraception (1). Most women resume sexual activity within 1 to 2 months (4, 5) and have a mean return to ovulation of 45 days for non-breast feeding mothers (6). A woman returning for IUD insertion 4-8 weeks after delivery is therefore putting herself at risk for unintended pregnancy. In addition, missing the postpartum visit is a significant barrier to postpartum contraceptive use (7,8). Insurance coverage is often an associated barrier. Inserting an IUD immediately postpartum is a way to overcome the barriers of changing insurance coverage and having to return for the postpartum visit before obtaining long acting reversible contraception.

Eligibility for this program is detailed below. It is important to note that some patients that may be eligible because their insurance does not cover immediate post placental contraception would prefer to receive an IUD 6-8 weeks post partum because of the lower expulsion rate. This option should be discussed with them.

Eligibility

All Post-placental IUDs must be placed under the direct supervision of a OB-Gyn attending physician until the provider has documented 10 post-placental IUD placements.

Eligible patients identified on admission will sign a standard consent for post-placental insertion. The consent should state that the rate of expulsion is 12% and this is higher than expulsion for IUDs placed 6 weeks postpartum. This is not a research study.
After a order is placed in POE (or faxed to pharmacy if POE not available), the device will be obtained from the pyxis. The nurses will be able to obtain the device from the pyxis and will enter the patient information, IUD type, and log number in the designated post-placental IUD book.

Inclusion criteria:
1. any age; adolescents may receive post-placental IUD insertion
2. desiring Paragard or Mirena IUD
3. anticipated vaginal (including vaginal birth after cesarean) or cesarean delivery
4. any language for which adequate translation can be obtained

Exclusion criteria:
1. history of sexually transmitted infection during the index pregnancy
2. recent (within the last 3 months) or active intrauterine infection
3. known abnormal uterine cavity
4. standard absolute contraindications (eg: Wilson’s disease, no Paragard)

After enrollment, subjects should be excluded if:
1. intrapartum fever greater than 38.0 degrees
2. postpartum hemorrhage (greater than 500 ml blood loss for vaginal deliveries; 1,200cc for cesarean deliveries)
3. rupture of membranes for greater than 24 hours prior to delivery
4. retained placenta requiring manual removal or D&C

If subject cannot receive IUD, it must be returned to the pyxis. DO NOT OPEN IT UNTIL READY TO INSERT.

**Insertion Technique for Vaginal Delivery (NSVD, FAD, VBAC):**
- After uterine massage, but before perineal repair, change into new sterile gloves.
- Pitocin should be administered per routine.
- Prophylactic antibiotics are not routinely administered.
- Special or additional anesthesia is not needed.
- Remove IUD from the inserter.
- Place IUD between the index and middle fingers.
- Place the opposite hand on the abdomen to externally stabilize the uterus.
- Within 10 minutes of delivery of the placenta, insert the IUD to the top of the uterine fundus.
- To ensure fundal placement, the operator should feel the impact of the device against the fundus both internally and through the abdominal wall. Placing the device too low in the uterus may lead to expulsion.
- As the internal hand is removed, rotate it about 15 degrees to avoid dislodging the IUD.
- Paragard strings are 12 cm and should not be visualized after insertion; if the strings are visible, the IUD may be too low and reinserted should be considered. The strings usually descend spontaneously through the cervix and can be trimmed at a follow-up visit. If fundal placement is confirmed and strings are seen, trim to
the level of the cervix. Mirena strings should also be trimmed to the level of the cervix.

Manual insertion requires no instruments; however, it may be more painful than insertion with ring forceps or the IUD applicator in the absence of anesthesia.

**Insertion Technique for Ring forceps or Mirena IUD applicator:**
- Prepare the Mirena IUD applicator as usual or grasp the IUD with the ring forceps at a slight angle so that the ball of the stem and the strings are parallel to the forceps.
- If using ring forceps, the top of the IUD should be even with the tip end of the forceps.
- Using a hand or retractor, expose and visualize the anterior cervix.
- Grasp the cervix with another ring forceps.
- While retracting gently on the cervix and under direct visualization, introduce the IUD through the cervix into the lower uterus.
- Release the hand that was retracting the cervix and place it on the abdomen.
- Stabilize the uterus with this hand.
- Advance the IUD to the uterine fundus.
- Confirm fundal placement with both the abdominal hand and the inserting hand.
- Release the IUD from the ring forceps or Mirena IUD applicator.
- Rotate the ring forceps about 45 degrees and move it laterally to avoid dislodging the IUD. If using a Mirena IUD applicator, it can be removed in the typical fashion.
- Inspect the vagina; if Paragard strings are visible, the IUD may be placed too low and reininsertion should be considered. The strings usually descend spontaneously through the cervix and can be trimmed at a follow-up visit. If fundal placement is confirmed and strings are seen, trim to the level of the cervix. Mirena strings should also be trimmed to the level of the cervix.

**Insertion Technique for Cesarean Delivery:**
- At cesarean insertion, place the IUD at the top of the uterine fundus with ring forceps or manually. (Mirena strings may need to be trimmed prior to placement).
- Before closing the uterine incision, place the strings in the lower uterine segment.
- The strings will usually descend spontaneously through the cervix during the puerperal period.
- If the cervix is closed, dilate from above with ring forceps. Strings can be passed through the cervix with ring forceps. If this is done, recheck to make sure IUD remains at the fundus of the uterus prior to closing the uterine incision.
- Trim strings at a follow-up visit.
**Ultrasound Guidance:**
May be used at the provider’s discretion to assure fundal placement with vaginal deliveries. High fundal placement of the IUD lowers expulsion rates (9).

If ultrasound is used, insertion is guided by simultaneous transabdominal ultrasound. Pictures confirming the location of the IUD should be printed and placed in the patient’s chart.

**Counseling and Instructions:**

Ideally, postpartum family planning options should be discussed during the patient’s prenatal care and the patient offered post-placental IUD insertion as one choice among all available contraceptive options. If the patient presents with no prenatal care or without family planning counseling, counseling may be offered if the patient is in early labor.

Before discharge, the patient must be instructed about side effects, possible complications, and warning signs. She should be educated to recognize IUD expulsion and to return to clinic for reinsertion or an alternative contraceptive method. Almost all expulsions occur in the first three months after insertion (9). She should also be advised that within several weeks, the IUD strings may protrude through the introitus; the strings can be shortened at a follow-up visit.

**Documentation:**
The provider should document the IUD placement in the chart including procedure description, IUD type/lot number and any deviations from normal protocol.

**Follow-up:**
Women with post-placental IUD insertion should be scheduled for follow-up at four to eight weeks. Rates of return for postpartum visits have been shown to be significantly increased in programs offering in-hospital postpartum IUD insertion (9).

“Missing strings” are more common after postpartum IUD insertion than after interval insertion (9). This should be managed according to the usual clinic protocol for this situation.

Patients should be instructed that if the IUD is expelled then they will need another form of contraception. We can not confirm that the IUD is in the uterus (and that they can rely on this for contraception) until they follow up in clinic. At the postpartum visit, we will trim the IUD strings and evaluate for uterine placement.

**Special Considerations:**

STD screening:
- All patients should have documented negative Chlamydia/Gonorrhea testing during the pregnancy.
- Patients with positive results at any point during the pregnancy are not eligible for post-placental IUD insertion.
- If test results are not available, send GC/CT urine tests on admission. If results are found to be positive post insertion, treat with IUD in place. If any clinical evidence of infection, consider removal of IUD followed by treatment.

**Implanon**

Implanon is also available for qualifying patients. The subdermal device can be inserted at any point after delivery prior to discharge. The patient must complete both the hospital and manufacturer's consent. Insertion must be performed by a trained provider (NP, CNM or MD). It is understood that there may not always be someone available for this service.

**Questions:**
During regular business hours, please direct all questions regarding this protocol to Dr. Jennifer Hyer (303-201-2164). If Dr. Hyer is not available, please call the labor and delivery attending on vocera (303-436-3222).

**References:**