Immediate Postpartum LARC for Clinicians Doing Deliveries
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Speaker disclosures

• [Presenter to add any financial disclosures here]
Topics covered in presentation

Section 1: Unmet patient need for postpartum contraception
Section 2: Clinical considerations
Section 3: Assessing candidacy
Section 4: Contraceptive counseling
Section 5: Intrauterine devices (IUD) insertion techniques*
Section 6: Follow up instructions

* Note: The Food and Drug Administration requires all health care providers who perform implant insertions and removals receive training from the manufacturer. Therefore, the implant insertion process is not covered in this presentation.
Learning objectives

1. Understand the unmet contraceptive needs postpartum
2. Explain the efficacy and safety of LARC in the immediate postpartum period
3. Understand the importance of shared decision-making for contraceptive counseling
4. Understand immediate postpartum IUD insertion techniques
UNMET PATIENT NEED

for Postpartum Contraception
The need for postpartum contraception

- The greatest risk of low birth weight and preterm birth occurs when the birth to conception interval is <6 months

- Data suggests a modest increase in risk of adverse outcomes associated with intervals of <18 months

- The optimal interval between delivery and subsequent pregnancy is 18 months to 5 years
Challenges with initiating postpartum contraception

Patients may have difficulty returning for a postpartum visit because of:

- Childcare obligations
- Unable to get off work
- Unstable housing
- No transportation
- Communication or language barrier
- Lack of insurance coverage or potential expiration of Medicaid eligibility


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Challenges with initiating postpartum contraception

• As many as 40% of women do not return for the 6 week postpartum visit
  o Even lower in under-resourced areas, further contributing to health disparities

• Non-breastfeeding women can ovulate as early as 25 days postpartum
  o 40% of women will ovulate by 6 weeks postpartum

• 57% of women are sexually active by 6 weeks postpartum

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LARC can serve as a bridge method to tubal ligation

- At least 1/3 of women who want a postpartum tubal ligation will not have it done
- 47% of women discharged without having a desired postpartum tubal ligation will be pregnant within 1 year
- Issues preventing tubal ligation at the time of delivery:
  - Insurmountable systems barriers like lack of an operating room, physician availability, or incomplete consent forms
  - Insurance Issues
    - Medicaid coverage may end postpartum
    - Uninsured – cost of sterilization can be prohibitive
- Immediate postpartum LARC can serve as a bridge method for those unable to get a desired tubal ligation
What is LARC?

• LARC stands for **long-acting reversible contraception**

• 2 types of LARC: the **intrauterine device** and the **contraceptive implant**, which are the most effective reversible forms of contraception

• **Advantages** of LARC include:
  1. Methods do not require ongoing effort for long-term and effective use
  2. Rapid return to fertility after removal of the device

• **Disadvantage:** must be placed and removed by a trained clinician, which impacts patient autonomy
What is immediate postpartum LARC?

LARC methods are available to women in the hospital after a delivery before discharge

- ACOG, CDC, WHO, and Cochrane Reviews all support immediate postpartum LARC as a safe and effective option
- Can be an ideal time to provide LARC methods for many women who want them
Definitions: timing of LARC placement

1. **Immediate postplacental** – placement while still in the delivery room and, when possible, within 10 minutes of placental delivery

2. **Immediate postpartum** – placement during hospital admission for delivery

3. **Postpartum** – placement within 6 weeks of delivery

4. **Interval placement** – placement at any time during the menstrual cycle and not in relationship to the end of a pregnancy (or >6 weeks after delivery)
IPP LARC satisfaction & continuation rates

• Many women like and continue using their immediate postpartum LARC method
  
  o 74% of women who had an IUD placed immediately postpartum had their IUD in place at one year
  
  o 84% of women who had an implant placed immediately postpartum still had the implant at one year

• Elective discontinuation for IUDs and implants are similar with interval placement
IPP LARC can help meet patients’ needs

- Safe
- Convenient
- Highly effective
- Reversible
- Forgettable
- High continuation rates
CLINICAL CONSIDERATIONS
of Immediate Postpartum Contraception
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| Barrier Methods (condoms, diaphragm)        | 12-21%                   | - Must use with every act of intercourse  
- Condoms are only method that prevent STI transmission |
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- Must breastfeed infant frequently & exclusively; be amenorrhoeic, and <6 months postpartum |
| Fertility awareness-based methods | 24%                      | - Continuation rates are low (47% at 1 year)  
- Requires active participation by a willing partner  
- Requires daily action(s)  
- Requires lead time to increase effectiveness |
<p>| Withdrawal                       | 22%                      |                                                                                       |</p>
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## Comparing LARC Methods

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<tr>
<th></th>
<th>ParaGard® CopperT 380A</th>
<th>Liletta®</th>
<th>Mirena®</th>
<th>Kyleena®</th>
<th>Skyla®</th>
<th>Nexplanon®</th>
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<tr>
<td><strong>Hormone and Dose</strong></td>
<td>Non-hormonal</td>
<td>52mg LNG (18.6 mcg/day)</td>
<td>52mg LNG (20 mcg/day)</td>
<td>19.5mg LNG (17.5 mcg/day)</td>
<td>13.5mg LNG (14 mcg/day)</td>
<td>68mg ENG (35-45 mcg/day)</td>
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<td><strong>Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt; 99%</td>
</tr>
<tr>
<td><strong>FDA-Approved Duration of Use</strong></td>
<td>10 years</td>
<td>6 years</td>
<td>5 years</td>
<td>3 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expected Bleeding Patterns</strong></td>
<td>Typically heavier</td>
<td>Typically lighter – rates of amenorrhea associated with hormone dose</td>
<td></td>
<td></td>
<td></td>
<td>Typically lighter, often unpredictable</td>
</tr>
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* Ongoing studies suggest high efficacy with extended use beyond FDA-approved durations

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Levonorgestrel (LNG) IUD

- Mechanism of action:
  - Prevents fertilization by changing amount and viscosity of cervical mucus, making it impenetrable to sperm
- Does not disrupt pregnancy and is not an abortifacient
- Most women ovulate normally, but experience diminished menstrual bleeding because of the local effect of levonorgestrel on the endometrium
- 99.8% effective; the one-year typical use failure rate is 0.2 per 100 women

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Copper IUD

- **Mechanism of action:**
  - Inhibition of sperm migration and viability
- Contains no hormones
- Does not disrupt pregnancy and is not an abortifacient
- The most common adverse effects reported are abnormal bleeding and pain
- 99.2% effective; the one-year typical use failure rate is 0.8 per 100 women
- Most effective method of emergency contraception when inserted within 5 days of unprotected intercourse

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Etonogestrel (ENG) implant

- **Mechanism of action:**
  - Primary: ovulation suppression
  - Additional: thickening of cervical mucus and alteration of the endometrial lining

- After implant insertion, changes in bleeding patterns are common and include amenorrhea or infrequent, frequent, or prolonged bleeding

- Placed subdermally in upper arm
  - Size: 4cm x 2mm (comparable in size to a match stick)

- 99.9% effective; the one-year typical use failure rate is 0.05 per 100 women

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Troubleshooting Side Effects

• Consider including these tips during counseling so patients can try them before an in-person appointment:
  o Copper IUD
    • To prevent heavy and painful menses: Take ibuprofen 400mg every 4 hours for 7 days starting Day 1 of menses for the first 3-6 cycles
  o LNG-IUD and ENG Implant
    • For unscheduled bleeding: Take naproxen 500mg every 12 hours for 5 days OR ibuprofen 800mg every 8 hours for 5 days

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ASSESSING CANDIDACY
for Immediate Postpartum LARC
ACOG guidance for postpartum LARC

Key Takeaway:

“ACOG supports immediate postpartum LARC insertion as a best practice, recognizing its role in preventing rapid repeat and unintended pregnancy.”

- ACOG Practice Bulletin #186, LARC: IUDs & Implants
IPP IUD contraindications Category 4 – ACOG & U.S. MEC

### Routine Contraindications
- Active gynecologic malignancy
- Current breast cancer
- Current active purulent cervicitis, chlamydial/gonococcal infection, or PID*
- Gestational trophoblastic disease with persistent intrauterine disease or malignancy
- Pelvic tuberculosis
- Post-abortion or postpartum sepsis
- Uterine anomaly
- Unexplained vaginal bleeding

### IPP Contraindications
- Uterine infection:
  - Peripartum chorioamnionitis
  - Endometritis
  - Puerperal sepsis
- Ongoing Postpartum hemorrhage

*STI testing should be done as indicated, but IUD insertion does not require testing & should not be delayed while awaiting test results.


IPP LARC & infection

Key Takeaway:

“IPP IUD placement is contraindicated in the setting of intrauterine infection at time of delivery, postpartum hemorrhage, and puerperal sepsis. In the absence of puerperal sepsis, IPP IUD insertion is not associated with increased risks of bleeding or infection.”

- ACOG Committee Opinion #670, Immediate Postpartum LARC
IPP LARC & infection

• Treat per your usual clinical practice if:
  o Endometritis develops after IPP IUD insertion
  o Infection occurs after insertion or removal of the implant

• Currently, minimal data exists on IPP IUD and subsequent development of endometritis
  o Recommendations are based on expert opinion
  o ACOG has no official guidance on treating IPP IUD and endometritis

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IUD EXPULSION

Clinical Considerations
IUD expulsion

- Expulsion rates for immediate postpartum IUD insertions vary by:
  - Study
  - Device type
  - Route of delivery

- Expulsion rates:
  - Immediate postplacental: ~10%
  - 10 minutes to 4 weeks: may be as high as 10-27%

- Continuation rates for IUDs and implants at 1 year are similar with interval placement
IUD expulsion

• Counsel patients about increased risk of expulsion and signs and symptoms of expulsion

• A person who experiences or suspects expulsion should contact their health care provider and use a back-up contraceptive method
IUD expulsion

Key Takeaway:

Many women experience barriers to interval LARC placement, such that the advantages of immediate placement outweigh the disadvantages.

“The immediate postpartum period has several potential benefits for implant insertion or IUD placement because women are known not to be pregnant and many women are motivated to avoid short-interval pregnancy. Additionally, the woman and clinician are in the same place at the same time, which eliminates potential access barriers, including the need for an additional visit and potential loss of insurance coverage postpartum.”

- ACOG Committee Opinion #670, Immediate Postpartum LARC
BREASTFEEDING

Clinical Considerations
Breastfeeding

• The Copper IUD lacks hormones and is classified as CDC MEC Category 1 (no restriction on use) for people who are breastfeeding.

• The LNG IUD and implant are category 2 for theoretical impact on lactation.

• Several small randomized control trials (RCTs) have shown no significant differences in:
  
  o Breast milk quality or quantity
  o Infant size

Breastfeeding

Key Takeaway:

“Given available evidence, women considering IPP hormonal LARC should be counseled about the theoretical risks of reduced duration of breastfeeding, but the preponderance of evidence has not shown a negative effect on actual breastfeeding outcomes”

- ACOG Practice Bulletin #186, LARC: IUDs & Implants
CONTRACEPTIVE COUNSELING

Shared Medical Decision-Making
• Contraceptive coercion is the act of pressuring or forcing an individual to use a method of birth control that they do not desire.

• The U.S. has a long history of contraceptive coercion and forced sterilization perpetrated against economically marginalized individuals and persons of color.
Forced Sterilization

- The Eugenics movement of the early 1900s

- Continued forced or coerced sterilization through 1970’s of the economically marginalized, those with mental illnesses, persons of color, and immigrant individuals
  - Population control
  - Social control
  - Form of punishment
  - Extortion to ensure receipt of public assistance
  - Trainee education

- Recent cases in the 2000s in California prisons
Reproductive Injustices

- Mississippi Appendectomy
- Indian Health Services
- La Operación
- Oral contraception clinical trials
- Norplant and Depo Provera
Contraceptive counseling, especially on sterilization or LARC methods, must be sensitive to this history.
Reproductive justice

SisterSong defines reproductive justice as:

“The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”

- SisterSong Women of Color Reproductive Justice Collective
A reproductive justice framework for contraceptive counseling

Key Takeaway:

“The framework of reproductive justice connects family planning and other aspects of sexual and reproductive health with the disparities and complexities that affect patients’ lives. Furthermore, it encourages gynecologic health care providers to examine issues of bias and coercion and advocate for equitable access and change.”

- ACOG Committee Opinion #699, Adolescent Pregnancy, Contraception, and Sexual Activity
Provider bias

- **Explicit bias**: a bias that a person is aware of and believes is correct in some manner.

- **Implicit bias**: a bias that is unintentional and unconscious but is activated quickly and unknowingly by situational factors.

- **Implicit association tests**: [https://implicit.harvard.edu/implicit/](https://implicit.harvard.edu/implicit/)

- **Consequences on patient-provider relationship include**:
  - Rapid discontinuation of methods that client felt pressured to select.
  - Delaying future healthcare access and contraceptive use due to previous negative encounters.
  - Undermining trust and decreased receptiveness to contraceptive counseling.
Shared medical decision making for contraceptive counseling

- **When engaging in shared medical decision making:**
  - Be aware of and address your own biases
  - Practice perspective-taking and individuation when caring for each person
  - Acknowledge historical racial injustices during counseling sessions
  - Strive for equitable outcomes for all people, especially for disadvantaged or marginalized groups.

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Talking with patients about contraception

• Shared medical decision making is a process where both patients and clinicians share information, express treatment preferences, and agree on a treatment plan.

• It can increase patient engagement and reduce risk, resulting in improved outcomes, satisfaction, and treatment adherence

• Although medical knowledge is tipped towards the provider, in shared medical decision making a middle ground is sought that incorporates accurate medical information and a patient’s personal preferences

• Person-centered goals may also have a part in the decision-making process

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5 components of shared medical decision making

1. Focus on interpersonal relationship.
2. Elicit patient preferences for methods.
3. Be attuned to diverse patient preferences.
4. Provide relevant information in accordance with patient preferences.
5. Be aware of and responsive to patient preferences during counseling.
5 components of shared medical decision making

1. Focus on interpersonal relationship
   Intimate, friend-like interactions establish trust and openness between providers and patients and are consistent with patient preferences for counseling about contraception.
   
   • Examples:
     o “Hi ____! It’s nice to see you again. How’s everything been since we saw each other last?”
     o “How are you liking the implant you received last time?”

2. Elicit patient preferences for methods
   Open the discussion of contraceptive method options with an open-ended question that provides a clear indication that the patients’ preferences are the focus of the discussion.

   • Examples:
     o “What brings you to our office today?”
     o “What is important to you about your birth control method?”
3. Be attuned to diverse patient preferences
Patients will have varied preferences around issues including the relative importance of preventing pregnancy and the significance of specific side effects, including menstrual changes.

- Examples:
  - “It’s really important for me to continue having a monthly period, so it’s less obvious I’m using contraception.”
  - “I absolutely cannot gain any weight.”

4. Provide relevant information in accordance with patient preferences
Prioritize sharing information about methods based on what is most important to the patient, whether that is side effects, efficacy, mode of use, or other method characteristics.

- Examples:
  - “Since you said you want regular menses, you might consider oral contraceptive pills.”
  - “I hear you. The injectable contraceptive is the only method proven to cause weight gain, but every body reacts differently so we can work together to see which method works best for you.”
5 components of shared medical decision making

5. Be aware of and responsive to patient preferences during counseling
Either through direct questioning or by assessing her response to a shared decision making approach, understand and adjust counseling, and specifically the extent of provider guidance in the decision-making process according to how the patient would like decisions to be made.

• Examples:
  o “Do you want to use a method that you can easily start and stop on your own?”
  o “How do you feel about having to take a pill at the same time everyday? Does that fit into your daily life?”

Remember the goal! Be person-centered.
Video: Initiation of a shared decision-making process

LARC COUNSELING SCENARIOS:
Initiation of Shared Decision Making Process

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Talking with patients about LARC

- Highlight the reliance on a provider for insertion/removal

- Be mindful that LARC can cause a decreased sense of control or the feeling of being pressured into a contraceptive method

- Discuss options for low or no-cost removal services, including Title X or other clinics

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Immediate postpartum LARC counseling

• Optimally, patients should be counseled prenatally

• Counseling on immediate postpartum LARC should include:
  o **All** indicated forms of contraception
  o Advantages, contraindications, and alternatives
  o Increased risk of expulsion, including unrecognized expulsion of IUD
  o Convenience and effectiveness, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals
  o A discussion on the theoretical risk of reduced duration of breastfeeding
  o Possibility of non-visualized strings and difficult removal

• More info & resources: [ACOG Postpartum Contraceptive Access Initiative Website](http://journals.lww.com/greenjournal/pages/results.aspx?txtkeywords=10.1097%2fAOG.0000000000001587)
Tools for contraceptive counseling

Bedsider.org

U.S. MEC phone app
Video: Shared decision making using a decision aid
Video: Responding to patient concerns
Video: Patient requesting implant removal

Trauma-informed care

- Trauma-informed care is an approach that:
  - Uses a framework that acknowledges the effects of trauma
  - Recognizes signs and symptoms of trauma
  - Responds by integrating knowledge about trauma into practices
  - Seeks to resist re-traumatization

- **Acute trauma**: single traumatic event that causes extreme emotional or physical distress

- **Chronic trauma**: ongoing traumatic event, such as abuse or neglect over time, multiple experiences of single events, or chronic traumatic experiences such as mistreatment and discrimination affecting a person’s sense of self in the world
Trauma-informed care

Key Takeaway:

“This [trauma-informed care] framework can help optimize the patient–provider relationship, improve health outcomes, and reduce long lasting burdens of trauma.”

- ACOG Committee Opinion #777, Sexual Assault
IUD INSERTION

Immediately Postpartum
Post-placental IUD insertion equipment

- Two forceps
  - One for cervical traction and another for device placement
    - Kelly Placental forceps
    - Ring/Ovum forceps
- Method of vaginal retraction
- Scissors
- Light source
- IUD
- New sterile gloves
- Ultrasound recommended, not required
- +/- antiseptic cleanser and radiopaque surgical sponge

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Importance of fundal placement

- Fundal placement is key to decreased expulsions rates
- The ACOG LARC Work Group recommends ultrasound guidance for insertion, especially during training, but lack of availability should not preclude insertion
IUD ring forceps method

1. Identify cervix, place atraumatic (ring) forceps on anterior lip of cervix
2. Grasp the IUD with the forceps but do **NOT** close the ratchets
3. Insert the forceps through the cervix
4. Place non-forceps hand on the abdomen, palpating the fundus
5. Move the IUD-holding forceps up to the fundus
6. Open the forceps to release the IUD
7. Slowly remove the forceps, keeping them slightly open
8. Cut the strings flush with the external os
   • Strings will lengthen with uterine involution, and may require trimming
   • Alternatively, may pre-cut strings to 10 cm from the top of the device

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IUD manual insertion method

1. Grasp the IUD between your 2\textsuperscript{nd} and 3\textsuperscript{rd} fingers
2. Insert your hand to the fundus
3. Use your other hand to palpate the fundus abdominally to confirm
4. Slowly open your fingers and remove them from the uterus
5. Cut the strings flush with the external os
   - Strings will lengthen with uterine involution, and may require trimming
   - Alternatively, may pre-cut strings to 10 cm from the top of the device

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IUD insertion tips & tricks after vaginal delivery

• Put on new sterile gloves before beginning
• Retrieve the ultrasound prior to delivery, if possible
• Ensure appropriate bleeding
  o Uterine tone
  o Complete placental removal
• Ring forceps for cervical traction, if needed
• Repair bleeding lacerations first, but repair non-bleeding lacs afterward
• If difficulty reaching fundus, lower your hand and adjust speculum/retractor as needed to change the angle of insertion such that the curve of the lower uterine segment can be navigated

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Cesarean delivery: Postplacental IUD placement

1. Perform routine external massage and internal sweep to ensure all placental tissue is removed.
2. Ensure the uterus is hemostatic and initiate closure of the hysterotomy.
3. Grasp the body of the IUD with forceps, hand or inserter.
4. LNG IUD strings should be trimmed to about 10 cm from the top of the device.
5. Strings of the ParaGard copper IUD do not need to be trimmed.
6. Place the IUD at the fundus.
7. Carefully point strings to cervix/vagina.
8. Complete hysterotomy closure – take care to not incorporate the strings into the closure.

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IUD removal

• Patients can have an IUD removed at any time upon request
• Prophylactic antibiotics are NOT needed for IUD removal
• Providers should be aware of changes to insurance coverage in the postpartum period that may affect coverage of device removal for patients
• Discuss with the patient:
  o When fertility could return
  o Contraceptive options if pregnancy is not desired
  o Mild uterine cramping and a small amount of bleeding is expected
  o Options for low or no-cost removal services, including Title X or other clinics

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IUD removal

- **Instruments needed**: speculum, ring forceps (+/-: cytobrush and tenaculum)

- **Removal technique**: Once the cervix is visualized, grasp the strings with the ring forceps, and apply steady traction to remove the IUD

- **Note**: Ensure the IUD has been removed in its entirety

- More info & resources: [ACOG LARC Program’s Video Series-IUD Removal](https://www.acog.org)
Non-Visualized IUD strings

- **Potential causes:** string retraction (in cervix or uterus), IUD failure/pregnancy, IUD expulsion, perforation

- **Step 1:**
  - Attempt to sweep strings retracted in the cervical canal into view with a cytobrush

- **Step 2:**
  - If strings remain unidentified, then the patient should undergo a pregnancy test, counseling regarding emergency contraception and backup method of contraception should be provided, and ultrasound imaging should be performed
    - If ultrasound demonstrates a correctly placed IUD: it may continue to be relied upon for contraception (if desired by patient) or it may be removed
    - If ultrasound does not locate the IUD: the patient should receive an abdominal X-ray to rule out expulsion and perforation

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Non-Visualized IUD String Removal*

- Always confirm IUD is in the uterus
- **Instruments needed:** speculum, ring forceps, tenaculum, alligator or Bozeman forceps, ultrasound, lidocaine (for paracervical block), +/- mechanical dilators, IUD hook
- **Removal technique:** Under ultrasound guidance following paracervical block, pass the alligator forceps through the cervix and into the uterus. Grasp the IUD and apply steady traction.
- **Note:** Ensure the IUD has been removed in its entirety
- **More info:** [ACOG LARC Program’s Video Series-Complicated IUD Removal](https://journals.lww.com/greenjournal/Fulltext/2016/09000/Committee_Opinion_No_672__Clinical_Challenges_of.55.aspx)

* This technique should only be carried out by experienced clinicians.
IMPLANT INSERTION

Key Considerations
Contraceptive implant insertion

• The Food and Drug Administration requires that all health care providers who perform implant insertions and removals receive training from Merck, the manufacturer of Nexplanon®.
  o The insertion process is provided by Merck and not covered in this presentation

• To request a Nexplanon® training:
  2. Phone number: 1-877-467-5266
Implant follow up

• Immediate postpartum insertion of the contraceptive implant is identical to interval insertion and can be inserted any time after delivery

• Instruct patient to make a follow up appointment if:
  o Experiencing redness, swelling, or drainage near the implant insertion site
  o Unable feel the implant under their skin

• Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks

• Providers should be aware of changes to insurance coverage in the postpartum period that may affect coverage of device removal for patients
  o Discuss options for low or no-cost removal services, including Title X or other clinics
Implant removal

• Patients can have an implant removed at any time upon request

• Discuss with the patient:
  o When fertility could return
  o Contraceptive options if pregnancy is not desired

• If the implant is not palpable, pregnancy should be excluded and patients should be offered a method of backup contraception until the implant is located

• The removal process is included in the training required to be provided by Merck, the manufacturer of Nexplanon®, and is not covered in the presentation

• More info & resources: ACOG LARC Program’s Video Series-Implant Removal

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Video: Patient requesting implant removal

FOLLOW UP INSTRUCTIONS

for Immediate Postpartum LARC
Postpartum IUD follow-up instructions

• All patients should be offered a string check (not mandatory)

• Instruct patient to notify a provider if they have:
  ○ Fevers, chills, severe abdominal pain, or temperature > 100.4°F
  ○ Heavy bleeding
  ○ Pain not controlled by over the counter medicine
  ○ Expulsion of the device
  ○ Pain or cramping different from lochia or postpartum cramps

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Postpartum implant: follow-up instructions

• Immediate postpartum insertion of the contraceptive implant is identical to interval insertion and can be inserted any time after delivery

• Instruct patient to make a follow up appointment if:
  o Experiencing redness, swelling, or drainage near the implant insertion site
  o Unable feel the implant under their skin

• Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks

• Providers should be aware of changes to insurance coverage in the postpartum period and how that may affect coverage of device removal for patients
  o Discuss options for low or no-cost removal services, including Title X or other clinics
KEY TAKEAWAYS & RESOURCES

Things to Keep in Mind
Summary of ACOG recommendations

1. Contraceptive counseling should use **shared medical decision-making** and include **all** contraceptive options.

2. Contraceptive counseling should include **benefits** and **limitations** of all methods.

3. LARC methods have **few contraindications** and almost all women are eligible for implants and IUDs.

4. The immediate postpartum period can be particularly **favorable time** for IUD or implant insertion.

5. Immediate postpartum IUD placement is **cost-effective** despite higher expulsion rates and concerns related to **expulsion** and **breastfeeding** should be discussed.

6. Providers should be aware of changes to insurance coverage in the postpartum period and how that may affect **coverage of device removal** for patients.

6. Discuss options for **low or no-cost removal services** for LARC.

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The ACOG LARC Program can help!

- Email us: pcai@acog.org
- Find more resources online:
  - https://pcainitiative.acog.org
  - https://www.acog.org/programs/long-acting-reversible-contraception-larc
- Send us your LARC-related questions:
  - www.acoglarc.freshdesk.com
  - The LARC Program Help Desk is a free service open to all, ACOG members and non-members alike
  - All questions will be responded to within 10 business days.

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QUESTIONS?

List contact information here
ACOG guidance on contraceptive counseling

ACOG has many contraceptive counseling resources, including, but not limited to:

1. ACOG Practice Bulletin #186, LARC: Implants and Intrauterine Devices
2. ACOG Committee Opinion #672, Clinical Challenges of LARC Methods
3. ACOG Committee Opinion #670, Immediate Postpartum LARC
4. ACOG Committee Opinion #699, Adolescent Pregnancy, Contraception, and Sexual Activity
5. ACOG Committee Opinion #490, Partnering With Patients to Improve Safety
6. ACOG Committee Opinion #587, Effective Patient-Physician Communication
7. ACOG Committee Opinion #736, Optimizing Postpartum Care
8. Obstetric Care Consensus #8: Interpregnancy Care
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