Long Acting Reversible Contraception
Overview & Hands-On Practice for Residents
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Speaker disclosures

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

Section 1: Introduction to contraception
Section 2: Contraceptive counseling
Section 3: LARC overview
Section 4: Interval LARC with IUD insertion practice*
Section 5: Immediate postpartum LARC with IUD insertion practice*
Section 6: Key takeaways & resources

* 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.

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CONTRACEPTION

Introduction
Birth control options

The Implant (Nexplanon)

IUD (Skyla)

IUD (Mirena)

IUD (ParaGard)

Sterilization, for men and women

The Pill

The Patch

The Ring

The Shot (Depo-Provera)

Withdrawal

Diaphragm

Fertility Awareness

Condoms, for men and women
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- Condoms are only method that prevent STI transmission |
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# Comparing LARC Methods

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CONTRACEPTIVE COUNSELING

Shared Medical Decision-Making
Contraceptive coercion

- 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

Slide content courtesy of Dr. Serina Floyd
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Contraceptive counseling, especially on sterilization or LARC methods, must be sensitive to this history.
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

Slide courtesy of Dr. Serina Floyd

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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.
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
5 components of shared medical decision making

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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. 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:
  - “Do you want to use a method that you can easily start and stop on your own?”
  - “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
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

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Tools for contraceptive counseling

Bedsider.org

U.S. MEC phone app

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Video: Shared decision making using a decision aid

LARC COUNSELING SCENARIOS:

Shared Decision Making Using a Decision Aid
Video: Responding to patient concerns

LARC COUNSELING SCENARIOS:
Responding to Patient Concerns

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Video: Patient requesting implant removal

LARC COUNSELING SCENARIOS:

Patient Requesting Implant Removal
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
LARC METHODS

Overview
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

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Levonorgestrel (LNG) IUD

• Mechanism of action:
  o 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
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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IUD contraindications category 4 – ACOG & U.S. MEC

- 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
- Pregnancy
- Uterine anomaly
- Unexplained vaginal bleeding

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


CLINICAL CASE QUESTIONS

Breakout Session 1
Download the CDC contraception app on your smartphone now

- **Medical Eligibility Criteria (MEC)**
  - Recommendations for the use of specific contraceptive methods by patients who have certain characteristics or medical conditions.

- **Selected Practice Recommendations (SPR)**
  - Addresses a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods.
Case 1:
A 30 yo G2P2 presents to your office 2 weeks postpartum. She is currently breastfeeding. She has used combined oral contraceptives in the past and asks about starting them again.

• What does she need to know about combined oral contraceptives?

• What are her birth control options?
  ○ Currently?
  ○ Four weeks from now?
Case 2:
A 20 yo G0 with a history of depression presents to your office for contraceptive counseling. After exploring what is most important to her in a method, she says she wants it to be very effective at preventing pregnancy. Also, she wouldn’t mind having lighter periods.

- What are her birth control options?
- What do you recommend?
Case 3:
A 38 yo G3P3 has a history of “headaches.” She is in a new relationship and wants to start on birth control. What are her options if she has:

- Tension headaches?
- Migraine headaches without aura?
- Migraine headaches with aura?
- Does her age matter?
- What if she smokes?
Case 4:
A 25 yo Go presents for contraceptive counseling. She has used pills in the past, but doesn’t take them consistently. She also reports “a lot of side effects” from the pill and doesn’t want to use hormones.

- What are her birth control options?

- What do you recommend?
Case 5:
A 40 yo G3P2 female has a history of hypertension. On review of her prior visits, you see that her blood pressure ranges from controlled at some visits to uncontrolled at others. Today her blood pressure is 145/92 and she states she took her anti-hypertensive this morning. She does not want to get pregnant.

• What are her birth control options?

• What do you recommend?
Case 6:
A 28 yo presents to your office for IUD insertion. How can you be reasonably certain she is not pregnant before you place the IUD?

If she had unprotected intercourse 4 days ago, can she still have an IUD?
BREAK

10 minutes
IUD INSERTION

Interval Placement
IUD insertion equipment

- Speculum
- Povidone-iodine and swabs or sponges (ring forceps if needed)
  - Use chlorhexidine for povidone-iodine, iodine or shellfish allergy
- Tenaculum
- Uterine sound
- IUD device and inserter
- Scissors
- Light source
- New sterile gloves or non-sterile gloves using no-touch technique
- +/-: Ultrasound, cervical dilators, lidocaine (may help with difficult insertions)
ParaGard® IUD insertion
HANDS-ON: INTERVAL IUD INSERTION

Breakout Session 2
INTERVAL LARC INSERTION

Clinical Considerations
Interval IUD complications

**Expulsion**
- The expulsion rate is between 2-10% during the first year

**Perforation**
- Occurs in 1.4 per 1,000 LNG-IUD insertions
- Occurs in 1.1 per 1,000 Cu-IUD insertions

**Infection**
- Rare
- Routine antibiotic prophylaxis is not recommended before IUD insertion
IUD follow-up instructions

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

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

• FAQs
  o When is it okay to: Have sex? Take a bath? Use a tampon?
  o Does it work right away or should I use condoms?
Backup contraception

- **ParaGard®**: None needed

- **LNG IUDs (Mirena®, Liletta®, Kyleena® & Skyla®)**:
  - If inserted within the first 7 days since menstrual bleeding started, no additional contraceptive protection is needed
  - If inserted > 7 days since menstrual bleeding started, abstain from sexual intercourse or use additional contraceptive protection for the next 7 days

- **Nexplanon®**:
  - If inserted within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed
  - If inserted > 5 days since menstrual bleeding started, abstain from sexual intercourse or use additional contraceptive protection for the next 7 days

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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
• 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
• More info & resources: [ACOG LARC Program’s Video Series-IUD Removal](#)
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
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.

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IMPLANT INSERTION

Interval Placement
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®.
  ○ 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 instructions

• Instruct patient to notify provider and 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

• Review where a patient can go to get the implant removed if needed
Implant removal

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

- Discuss with patients:
  - When fertility could return
  - 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
Summary of ACOG recommendations

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

2. Contraceptive counseling should include **all** contraceptive options

3. LARC should be offered as a **safe** and **effective** option using **shared medical decision-making**

4. **Counsel patients** regarding need for back-up method, STI prevention, expected menstrual changes, follow up, and removal options

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BREAK

10 minutes
IMMEDIATE POSTPARTUM LARC

Overview
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
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

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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

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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
  - 74% of women who had an IUD placed immediately postpartum had their IUD in place at one year
  - 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
ASSESSING CANDIDACY
for Immediate Postpartum LARC
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
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

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# 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

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*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
IUD EXPULSION

Clinical Considerations
IUD expulsion

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

• Expulsion rates:
  o Immediate postplacental: ~10%
  o 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

- 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:
  - Breast milk quality or quantity
  - 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
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

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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
  - Uterine tone
  - 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 or hand
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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Immediate Post-Placental IUD Insertion - NSVD
Immediate postpartum IUD follow-up instructions

• If patient experiences bleeding or cramping different from lochia or postpartum cramps:
  o Instruct patient to inspect pads for evidence of expelled IUD
  o Make an appointment for evaluation of possible partial expulsion

• Instruct patient to remind their provider that an IUD was placed postpartum and to notify a provider if they have:
  o Fevers, chills, severe abdominal pain, or temperature > 100.4°F
  o Heavy bleeding
  o Expulsion of the device

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Immediate postpartum IUD follow-up instructions

- Many patients need a follow-up appointment to have strings trimmed
  - Instruct patient to seek care and not adjust strings if bothersome
  - All patients should be **offered** an appointment to verify IUD location through ultrasound or a string check (not mandatory)

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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
IMPLANT INSERTION

Immediately Postpartum

©ACOG
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 to 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
CLINICAL QUESTIONS

Breakout Session 3
Clinical Question 1:

Counseling on immediate postpartum IUD insertion should include:

a) Increased risk of expulsion, including unrecognized expulsion
b) Signs and symptoms of expulsion
c) Increased risk of infection
d) Both A & B
e) Both A, B, & C
Clinical Question 2:

According to the CDC MEC, what risk category is the implant in regards to breastfeeding? Use your app!

a) Category 1 – no restriction
b) Category 2 – the advantages generally outweigh the theoretical or proven risks
c) Category 3 – the theoretical or proven risks outweigh the advantages
d) Category 4 – an unacceptable health risk
Clinical Question 3:

Which of the following is not a contraindication to a post-placental IUD?

a) Ongoing hemorrhage due to uterine atony
b) Intrapartum chorioamnionitis
c) Gestational diabetes
d) Bicornuate uterus
Clinical Question 4:

Short interpregnancy interval is associated with

a) Preterm delivery
b) Low birth weight infant
c) Pre-eclampsia
d) A and B
Clinical Question 5:

What proportion of women who leave without having a desired postpartum tubal ligation will be pregnant within 1 year?

a) 12%
b) 19%
c) 33%
d) 47%
HANDS-ON: IPP IUD INSERTION

Breakout Session 4
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

7. 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://pcainitiative.acog.org)

- Send us your LARC-related questions:
  - [www.acoglarc.freshdesk.com](http://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.
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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