IMMEDIATE POSTPARTUM LARC

FOR CLINICIANS DOING DELIVERIES

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SPEAKER DISCLOSURES

- **No financial disclosures**

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NOTE ON USE OF GENDERED LANGUAGE

Whenever possible ACOG utilizes gender neutral language to reflect the gender diversity of patients.

Otherwise, gendered language (terms such as “women,” “female,” et cetera) in this presentation is used to reflect language in the studies referenced.

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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.

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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

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UNMET PATIENT NEED

for Postpartum Contraception

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THE NEED FOR POSTPARTUM CONTRACEPTION

- Conception intervals of <6 months may be associated with low birth weight and preterm birth.
- 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

Interpregnancy care. Obstetric Care Consensus No. 8. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e51-72. Available at: https://oce.ovid.com/article/00006250-201901000-00051/HTML
Optimizing postpartum care. Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e949-51. Available at: https://journals.lww.com/greenjournal/Fulltext/2018/05000/ACOG_Committee_Opinion_No__736_Summary__.37.aspx.
Over-the-counter access to oral contraceptives. Committee Opinion No. 544. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012:120;1527-31. Available at: http://journals.lww.com/greenjournal/Abstract/2012/12000/Committee_Opinion_No__544___Over_the_Counter.46.aspx.

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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

Optimizing postpartum care. Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e949-51. Available at: https://journals.lww.com/greenjournal/Fulltext/2018/05000/ACOG_Committee_Opinion_No__736_Summary__.37.aspx.

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CHALLENGES WITH INITIATING POSTPARTUM CONTRACEPTION

- As many as 40% of women do not return for the 6 week postpartum visit
  - Even lower in under-resourced areas, further contributing to health disparities
- Non-breastfeeding women can ovulate as early as 25 days postpartum
  - 40% of women will ovulate by 6 weeks postpartum
- 57% of women are sexually active by 6 weeks postpartum

Optimizing postpartum care. Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e949-51. Available at: https://journals.lww.com/greenjournal/Fulltext/2018/05000/ACOG_Committee_Opinion_No__736_Summary__.37.aspx.

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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

Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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WHAT IS IMMEDIATE POSTPARTUM LARC?

LARC methods are available to patients 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 patients who want them

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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
    - Interval discontinuation rate: 20-22%
  - 84% of women who had an implant placed immediately postpartum still had the implant at one year
    - Interval continuation rate 82%
- Elective discontinuation for IUDs and implants are similar with interval placement

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IPP LARC CAN HELP MEET PATIENTS' NEEDS

- Safe
- Convenient
- Highly effective
- Reversible
- Forgettable
- High continuation rates

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CLINICAL CONSIDERATIONS

of Immediate Postpartum Contraception

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COMPARING LARC METHODS

	ParaGard® CopperT 380A	Liletta®	Mirena®	Kyleena®	Skyla®	Nexplanon®
Hormone and Dose	Non-hormonal	52mg LNG (18.6 mcg/day)	52mg LNG (20 mcg/day)	19.5mg LNG (17.5 mcg/day)	13.5mg LNG (14 mcg/day)	68mg ENG (35-45 mcg/day)
Efficacy	> 99%					
FDA-Approved Duration of Use	10 years*	8 years		5 years	3 years	3 years*
Expected Bleeding Patterns	Typically heavier	Typically lighter – rates of amenorrhea associated with hormone dose				Typically lighter, often unpredictable

* 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, 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

about the size of a quarter

Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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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

about the size of a quarter

Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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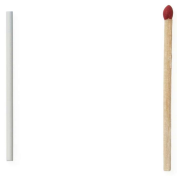
ETONOGESTREL (ENG) IMPLANT

- 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



Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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ASSESSING CANDIDACY

for Immediate Postpartum LARC

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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

Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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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

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

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Curtis KM, Tepper NK, Jatlaoui TC, Berry-Bibee E, Horton LG, Zapata LB, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(RR-3):1-103. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm?s_cid=rr6503a1_w.
Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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IPP LARC Contraindications

Key Takeaway:

"Immediate postpartum insertion is contraindicated for women in whom uterine infection (i.e., peripartum chorioamnionitis, endometritis, or puerperal sepsis) or ongoing postpartum hemorrhage are diagnosed (US MEC Category 4)"

- ACOG Committee Opinion #186, Long-Acting Reversible Contraception: Implants and Intrauterine Devices

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IPP LARC & INFECTION

- Treat per your usual clinical practice if:
  - Endometritis develops after IPP IUD insertion
  - Infection occurs after insertion or removal of the implant
- Currently, minimal data exists on IPP IUD and subsequent development of endometritis
  - Recommendations are based on expert opinion
  - ACOG has no official guidance on treating IPP IUD and endometritis

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IUD EXPULSION

Clinical Considerations

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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%
  - Interval: 3-10%
- Continuation rates for IUDs and implants at 1 year are similar with interval placement

Jatlaoui TC, Whiteman MK, Jeng G, Tepper NK, Berry-Bibee E, Jamieson DJ, Marchbanks PA, Curtis KM. Intrauterine Device Expulsion After Postpartum Placement: A Systematic Review and Meta-analysis. Obstet Gynecol 2018;132(4):895-905. Available at https://journals.lww.com/greenjournal/Fulltext/2018/10000/Intrauterine_Device_Expulsion_After_Postpartum.14.aspx
Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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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

Jatlaoui TC, Whiteman MK, Jeng G, Tepper NK, Berry-Bibee E, Jamieson DJ, Marchbanks PA, Curtis KM. Intrauterine Device Expulsion After Postpartum Placement: A Systematic Review and Meta-analysis. Obstet Gynecol 2018;132(4):895-905. Available at https://journals.lww.com/greenjournal/Fulltext/2018/10000/Intrauterine_Device_Expulsion_After_Postpartum.14.aspx
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IPP LARC SATISFACTION & CONTINUATION RATES

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IUD EXPULSION

Key Takeaway:

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

"the benefits of immediate insertion may outweigh the increased risk of expulsion. Disadvantages of waiting 4-6 weeks postpartum for interval insertion include failure to return for follow up and not obtaining an IUD at the follow-up visit."

- ACOG Committee Opinion #186, Long-Acting Reversible Contraception: Implants and Intrauterine Devices

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BREASTFEEDING

Clinical Considerations

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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

Legend:			
1	No restriction (*method can be used*)	3	Theoretical or proven risks usually outweigh the advantages
2	Advantages generally outweigh theoretical or proven risks	4	Unacceptable health risk (*method not to be used*)

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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

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CONTRACEPTIVE COUNSELING

Shared Medical Decision-Making

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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.

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

Slide content courtesy of Dr. Serina Floyd

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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

Dehlendorf C, Levy K, Kelley A, Grumbach K, Steinauer J. Women's preferences for contraceptive counseling and decision making. Contraception 2013;88:250-6. Available at: http://www.contraceptionjournal.org/article/S0010-7824(12)00901-8/fulltext

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IMMEDIATE POSTPARTUM LARC COUNSELING

- Optimally, patients should be counseled prenatally
- Counseling on immediate postpartum LARC should include:
  - All indicated forms of contraception
  - Advantages, contraindications, and alternatives
  - Increased risk of expulsion, including unrecognized expulsion of IUD
  - Convenience and effectiveness, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals
  - Theoretical risk of reduced duration of breastfeeding, but preponderance of evidence has not shown negative effects
  - Possibility of non-visualized strings and difficult removal
- More info & resources: ACOG Postpartum Contraceptive Access Initiative Website

Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251-69. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/11000/Practice_Bulletin_No__186___Long_Acting_Reversible.50.aspx.

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IUD INSERTION

Immediately Postpartum

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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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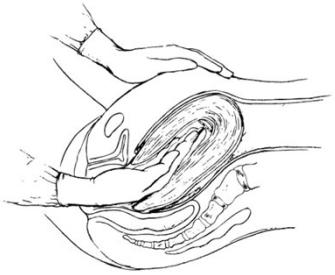
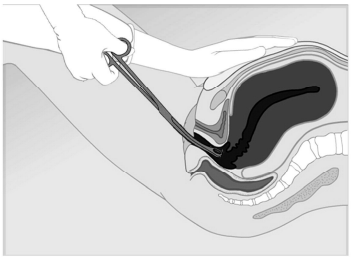
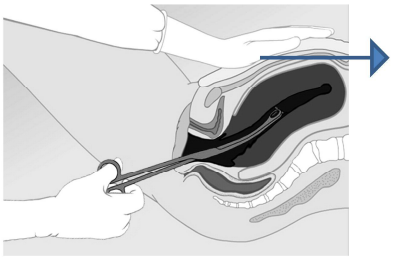
IMPORTANCE OF FUNDAL PLACEMENT

Manual Insertion



Instrument Insertion





- 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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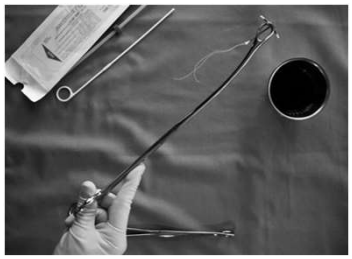
IUD RING FORCEPS METHOD

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 2nd and 3rd 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, 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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IPP IUD SIMULATION VIDEO: ACOG DISTRICT II

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IUD REMOVAL

- Patients can have an IUD removed <u>at any time upon request</u>
- Prophylactic antibiotics are <u>NOT</u> 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:
  - When fertility could return
  - Contraceptive options if pregnancy is not desired
  - Mild uterine cramping and a small amount of bleeding is expected
  - 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

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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

Clinical Challenges of Long-Acting Reversible Contraceptive Methods. Committee Opinion No. 672. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128(3):e69-77. Available at: https://journals.lww.com/greenjournal/Fulltext/2016/09000/Committee_Opinion_No_672__Clinical_Challenges_of.55.aspx.

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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

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

Clinical Challenges of Long-Acting Reversible Contraceptive Methods. Committee Opinion No. 672. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128(3):e69-77. Available at: https://journals.lww.com/greenjournal/Fulltext/2016/09000/Committee_Opinion_No_672__Clinical_Challenges_of.55.aspx.

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IMPLANT INSERTION

Key Considerations

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CONTRACEPTIVE IMPLANT INSERTION

- Immediate postpartum insertion of the contraceptive implant is identical to interval insertion and can be inserted any time after delivery
- 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:
  1. Website: http://www.nexplanon-usa.com/en/hcp/services-and-support/request-training/
  2. Phone number: 1-877-467-5266

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FOLLOW UP INSTRUCTIONS

for Immediate Postpartum LARC

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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:
  - Experiencing redness, swelling, or drainage near the implant insertion site
  - 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
  - Discuss options for low or no-cost removal services, including Title X or other clinics

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PRACTICE CASES

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QUESTION 1

In what situations below would placing an immediate post-partum IUD **NOT** be recommended? (please select all that apply)

A. Twin delivery

B. Postpartum hemorrhage that resolves during delivery

C. Postpartum hemorrhage with concern of continuation

D. Chorioamnionitis

E. Cesarean delivery

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QUESTION 2

A patient with no prenatal care presents in labor. During counseling and consenting process, they are informed about the option of placing an immediate postpartum IUD. What are some things to consider when consenting a patient for an immediate post-partum IUD insertion?

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QUESTION 3

What is the best way to place an immediate post-partum IUD?

A. Using ringed forceps for placement
B. Using hand for placement
C. Using IUD inserter for placement
D. A and B
E. All of the above

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KEY TAKEAWAYS & RESOURCES

Things to Keep in Mind

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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
5. 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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PLEASE COMPLETE TRAINING POST-TEST NOW

1. Open the Camera App on your smartphone.
2. Hold your device so that the QR code appears in the Camera App's viewfinder.
3. A notification should pop up. Tap the notification to open the link.

- OR –

Access the survey through the following weblink: bit.ly/2Yk2xLz

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PCAI
Postpartum Contraceptive Access Initiative

QUESTIONS?

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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 #490, Partnering With Patients to Improve Safety
5. ACOG Committee Opinion #587, Effective Patient-Physician Communication
6. ACOG Committee Opinion #736, Optimizing Postpartum Care
7. Obstetric Care Consensus #8: Interpregnancy Care

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Deleted slides, kept for reference

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Method	Pregnancy Rate in 1 Year	Special Considerations
Sterilization (female & male)	0.5%, 0.15%	- Permanent
Etonogestrel (ENG) Implant	0.05%	- Must be placed and removed by trained clinician - Clinicians must attend manufacture training prior to placement
IUD: Copper	0.8%	- Must be placed and removed by trained clinician
IUD: Levonorgestrel (LNG)	0.2%	- Must be placed and removed by trained clinician

TROUBLESHOOTING SIDE EFFECTS

- Consider including these tips during counseling so patients can try them before an in-person appointment:
  - 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
  - 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

Godfrey EM, Folger SG, Jeng G, Jamieson DJ, Curtis KM. Treatment of bleeding irregularities in women with copper-containing IUDs: A systematic review. Contraception. 2013;87(5):549-566. doi:10.1016/j.contraception.2012.09.006
Zigler RE, McNicholas C. Unscheduled vaginal bleeding with progestin-only contraceptive use. Am J Obstet Gynecol. 2017;216(5):443-450. doi:10.1016/j.ajog.2016.12.008

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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

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REPRODUCTIVE INJUSTICES

- Mississippi Appendectomy
- Indian Health Services
- La Operación
- Oral contraception clinical trials
- Norplant and Depo Provera

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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:
  - Experiencing redness, swelling, or drainage near the implant insertion site
  - 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
  - Discuss options for low or no-cost removal services, including Title X or other clinics

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IMPLANT REMOVAL

- Patients can have an implant removed at any time upon request
- Discuss with the patient:
  - 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

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