## 5.1 INTRAUTERINE CONTRACEPTIVE (IUC) CANDIDATE/INSERTION/REMOVAL OF DEVICE

<table>
<thead>
<tr>
<th>TITLE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>DEFINITION:</td>
<td>There are two types of IUCs (non-hormonal and progestin only) available in the United States, the Copper IUC and four levonorgestrel containing IUCs. Less than 1 user out of 100 becomes pregnant in the first year of using an IUC with typical use. IUCs are long-acting, reversible and can be used by clients with fallopian tubes/ovaries/uterus of all ages, including adolescents. IUCs can be inserted at any time if it is reasonably certain that the client is not pregnant. Labeling also supports placement immediately after delivery or abortion. IUDs work primarily by preventing sperm from fertilizing ova. Pregnancy is prevented by a combination of the “foreign body effect” of the plastic frame and the specific action of the active ingredient (copper or levonorgestrel) that is released. Exposure to a foreign body causes changes in the intrauterine environment that are toxic to sperm and ova and may impair implantation. The production of cytotoxic peptides and activation of enzymes lead to inhibition of sperm motility, reduced sperm capacitation and survival, and increased phagocytosis of sperm. Copper ions released by the TCu380A cause an increase in enzymes, prostaglandins, and white blood cells (macrophages) in uterine and tubal fluids; these impair sperm function and prevent fertilization. The progestin in LNG IUDs thickens cervical mucus, suppresses the endometrium by reducing uterine artery blood flow, and impairs sperm function by changing the uterine immune microenvironment. In addition, ovulation may be impaired as a result of systemic absorption of levonorgestrel. There is no evidence that IUDs disrupt an implanted pregnancy.</td>
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<tr>
<th>SUBJECTIVE:</th>
<th>Must Include:</th>
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<tr>
<td></td>
<td>1. LMP.</td>
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<td></td>
<td>2. No contraindications for IUC use per the current U.S. Medical Eligibility Criteria for Contraceptive Use.</td>
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<td>1.</td>
<td>Comprehensive medical, family, social, sexual, reproductive life plan and contraceptive history (initial, or updated as indicated).</td>
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<td>2.</td>
<td>Document any unprotected intercourse in last 5 days. Copper IUC can be inserted as emergency contraception up to 5 days after unprotected intercourse if the client desires long-term contraception.</td>
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<td>3.</td>
<td>If seeking removal of intrauterine devices, determine reason for removal.</td>
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<tr>
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<td>1. Age appropriate physical assessment, as indicated BP.</td>
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<td>2. Weight &amp; BMI as indicated.</td>
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<td>3. Normal pelvic exam (e.g., no signs of current vaginal or cervical infection, no sign of pregnancy).</td>
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<th>LABORATORY:</th>
<th>May Include:</th>
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<tr>
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<td>1. Pregnancy test if indicated.</td>
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2. Chlamydia and Gonorrhea screening, if indicated.
3. Wet mount to rule out bacterial vaginosis and trichomonas vaginitis, if symptomatic.

ASSESSMENT: Candidate for IUC use.

PLAN:
1. Provide information on effectiveness, benefits, side effects, and risks specific to intrauterine device. Client must demonstrate clear understanding of all information and counseling provided, as documented in the medical record. This must include a signed consent from either the manufacturer or clinic specific.
2. **Initiation of Paragard – copper IUC Device (CU-IUC):**
   a. The Cu-IUC can be inserted within 5 days of unprotected intercourse as an EC (see Progestin Only Contraceptives: Emergency Contraception).
   b. Switching from another contraceptive method: Cu-IUC can be inserted immediately if certain that the client is not pregnant. No additional contraceptive protection is needed.
   c. If immediate postpartum insertion – no additional contraceptive protection is needed.
   d. Post abortion (Spontaneous or Induced) Cu-IUC can be inserted within the first 7 days – no back-up method is needed.
3. **Initiation of LNG-IUC including Mirena, Skyla, Liletta or Kyleena**
   a. LNG-IUC inserted within first 7 days since menses, no additional back-up method is needed.
   b. If LNG-IUC inserted > 7 days since menses, the client will need to abstain from intercourse or use additional back-up method for 7 days.
   c. **Post abortion (Spontaneous or Induced):** the client will need to use back-up method or sustain from intercourse for next 7 days, unless inserted immediately post abortion.
   d. **If switching from the Cu-IUC to the LNG-IUC:** If client has had sexual intercourse since the start of their current menstrual cycle and it has been > 5 days since bleeding started, consider ECP at time of LNG-IUC insertion.
   e. **Special Considerations for LNG-IUC:** If client is > 21 days postpartum and not fully breastfeeding and no return of menses, client needs to abstain from intercourse or use a backup method for 7 days
4. Use of NSAIDs: advise IUC users to use NSAIDs prophylactically for first 3 months following IUC insertion (see IUC Complication-Excessive or Unscheduled Bleeding Variations).
5. Advise the client to return for routine health care or at any time to discuss side effects or other problems client may experience.
6. If IUC expulsion occurs within 3 months after insertion, consult with pharmaceutical representative for possible free replacement of device.

PROCEDURE: PLACEMENT OF INTRAUTERINE DEVICE
1. Premedication has not been found to decrease discomfort of IUC placement. **Routine use of misoprostol for IUC placement is not recommended. However, premedication may be considered if client has had a failed prior placement and with MD consultation.**
2. If client found to have BV, treat with systemic not topical metronidazole. No need to delay IUC placement but reinforce the importance of medication.
### TITLE
Clients with fallopian tubes/ovaries/uterus with current purulent cervicitis, chlamydial or gonococcal infection should not undergo IUC insertion until treatment is complete.

### 3. Important elements for placement include (Contraceptive Technology, Page 175):

- **a.** Perform a careful bimanual examination to identify the position and size of the uterus.
- **b.** Many clinicians wash the cervix with an antiseptic, such as povidone-iodine or chlorhexidine. However, no evidence supports this practice and its effect on bacterial colony counts in the endocervix is minimal.
- **c.** Although many people do not need anesthesia for IUD placement, lidocaine applied to the cervix (as a spray, gel, or injection) may increase comfort during tenaculum placement. A paracervical block is generally not indicated; however, it may be useful for those with a history of difficult or painful attempts at IUD placement or who require cervical dilation to facilitate insertion.
- **d.** Gently place a tenaculum on the cervix. Apply traction to the tenaculum to stabilize the cervix and straighten the axis of the uterus.
- **e.** Sound the uterus prior to placing the IUD. Advance the sound using the muscles in your fingers and wrist, not your elbow or shoulder.
- **f.** Place the IUD at the fundus, remove the insertion tube and trim the threads so they extend 3 to 4 cm from the os and are long enough to curl up in the fornix.
- **g.** Observe client for any signs of vasovagal response. To reduce the risk of vasovagal, have client strongly tense leg muscles, grip arm, or move fingers and toes. Document client’s response to procedure.

### EDUCATION:

#### PLACEMENT OF INTRAUTERINE DEVICE

1. Reinforce IUC education, including signs and symptoms of possible IUC complications (e.g., infection, expulsion, perforation, pregnancy). Because some IUD expulsions are asymptomatic, some clinicians encourage IUD users to routinely check their IUD threads, especially during the first 6 months of use, when risk of IUD expulsion is greatest.
2. Instruct client to seek urgent care if any symptoms of PID, heavy vaginal bleeding, severe cramping, or symptoms of pregnancy.
3. Discuss sexually transmitted infections and their associated risk(s) with an IUC.
4. Counsel on safer sex practices, consistent condom use.
5. Instruct client on the appropriate removal time for the IUC. Manufacturers suggested removal time include:
   - Recommendations for removal times will continue to be revised as new studies support longer time frames. Providers may use their discretion to extend recommendations for time frames based on clients’ needs if current agency protocols developed from nationally recognized organizations reflecting current standards of care are in place that support it.
6. Encourage annual well visits and to RTC PRN for problems.
7. Discuss risks of IUC if pregnancy occurs and need for IUC removal.
12. Advise client that infection risk is greatest within the first month of insertion.
13. Advise client of menstrual changes that can occur with IUC use.

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2. Discuss options for birth control if client is seeking different method.  
3. If seeking pregnancy counsel on preconception health. |

| PROCEDURE: REMOVAL OF INTRAUTERINE DEVICE | 1. The intrauterine device is removed by securely grasping the strings at the external os with ring forceps and applying steady gently outward traction, the device should easily be removed.  
2. Evaluate the intrauterine device to make sure it is intact.  
3. If IUC strings are not visualized and client desires removal, a cytobrush may be inserted into the endocervical canal, twisted, and then withdrawn in an attempt to pull retracted strings into view in the vagina.  
4. If the strings are not found with the cytobrush, an IUC hook may be used to locate the strings in the cervical canal or uterus.  
5. A tenaculum is placed on the cervix, the IUC hook is inserted into the cervical canal, and an effort is made to hook the strings and pull them into the vagina, where they can be grasped with ring forceps.  
6. If IUC threads are not found through the above interventions, refer for Ultrasound.  
7. Assess client immediately after procedure for any vasovagal response or pain.  
8. If unable to remove without difficulty to be referred. |

| REFFERAL TO MEDICAL PROVIDER: | 1. Any client who has difficult insertion or removal, or with a prior failed insertion or removal.  
2. Clients evaluated as category 3 per the current U.S. Medical Eligibility Criteria for Contraceptive Use. |

5. Milton, Sarah, MD Intrauterine Device Extraction Technique. |