

## Example Policy: Postpartum Intrauterine Device Insertion

### POLICY

1. A skilled physician with approved training for postpartum IUD insertion performs/supervises the IUD placement.
2. The IUD device should optimally be inserted within 10 minutes of placental delivery.
3. Postpartum IUD placement should be avoided in women >72 hours from delivery.
4. Transabdominal ultrasound guidance should be used for all insertions done outside the operating room (all insertions after vaginal deliveries and insertions done in c-section patients after the actual surgery is complete).
5. Patient should receive adequate counseling about risks, benefits, and alternatives to immediate postplacental/postpartum IUD insertion.
6. IUD Insertion can be performed using the IUD insertor, forceps or manually.

### PURPOSE

This document outlines safe, consistent practices for insertion of an intrauterine device (IUD) for long-acting reversible contraception following vaginal or cesarean delivery.

### DEFINITIONS

**Intrauterine device (IUD)** is a small, often T-shaped birth control device that is inserted into a woman's uterus to prevent pregnancy.

**Long acting reversible contraception (LARC)** refers to both the IUD and the subdermal implant.

**Chorioamnionitis/endometritis:** antibiotics given for fever/other symptoms in labor or post-delivery.

**Prolonged rupture of membranes:** rupture of membranes for greater than 24 hours.

**Immediate postplacental IUD placement:** IUD placed within 10 minutes of placental delivery

**Immediate postpartum IUD placement:** IUD placed >10 minutes after placental delivery but within 72 hours from delivery.

**Delayed IUD placement:** IUD placed >6 weeks after delivery.

### BACKGROUND

Immediate postplacental/postpartum IUD insertion is safe and effective (1). The American College of Obstetrics and Gynecologists (ACOG) has recommended LARC as the most effective and safe reversible contraceptive for women (2). Immediate postplacental/postpartum IUD insertion does not increase postpartum complications such as hemorrhage or endometritis (3). Several studies evaluating immediate postplacental/postpartum IUD insertion have identified higher expulsion rates in patients who underwent postpartum insertion when compared to patients who underwent insertions six weeks postpartum (4,5). However, an increased expulsion rate does not correspond to a decreased rate of IUD use as most expulsions are identified and addressed with insertion of another IUD or initiation of another contraceptive

method (6). In addition, studies show a high rate of non-insertion in patients indicating desiring an IUD postpartum during the prenatal period (7). This is in large part due to patients' failure to follow up for insertion postpartum. When the increased risk of expulsion associated with immediate post placental/postpartum insertion is balanced with the high rate of non-insertion in the delayed postpartum period, patients clearly benefit from having the option of immediate postplacental/postpartum insertion.

#### DESCRIPTION OF PROTOCOL

1. The physician should ascertain the patient is an appropriate candidate, and no contraindications are present for immediate postpartum IUD insertion.
2. Women presenting with the following are appropriate for a postpartum IUD insertion:
  - i) Desires long-acting reversible contraception
  - ii) Patient's with insurance coverage for immediate postpartum IUD insertion (Medicaid)
3. A postpartum IUD is contraindicated and should not be placed in the following cases:
  - i) Chorioamnionitis/endometritis
  - ii) Prolonged rupture of membranes (>24 hours)
  - iii) Unresolved postpartum hemorrhage
  - iv) Known uterine malformation
  - v) Greater than 72 hours from delivery
  - vi) +GC/CT testing in the third trimester
4. Patient should receive adequate counseling about risks, benefits, and alternatives to immediate postpartum IUD insertion. Counseling should also address issues particular to immediate postpartum insertion such as expulsion risk (10-27% for a vaginal delivery and 8% for intracesean placement) and management of IUD strings (higher chance of nonvisualization and potential for needing strings shortened).
5. Written informed consent for IUD insertion should be obtained prior to procedure.
6. Trained provider must be available for IUD insertion
7. Order must be placed for patient's preferred device (Paragard versus Liletta)
8. Procedure for immediate post-placental IUD insertion after vaginal delivery:
  - i) The provider ensures that an ultrasound is in the room for placement.
  - ii) The IUD device should optimally be inserted within 10 minutes of placental delivery.
  - iii) The IUD device may be replaced prior to repair of the perineum.
  - iv) The vaginal delivery should be performed per routine practice. This includes administration of the usual uterotonics as needed.
  - v) Do not open IUD packaging until ready to insert (waiting until this point avoids opening the IUD until it is sure to be placed, so it is not wasted if unable to be placed for any reason). To be opened onto sterile field by circulating nurse.
  - vi) The cervix is visualized and cleansed with Betadine.
  - vii) The anterior may be grasped with a ringed forceps
  - i) Insertion can be performed using the IUD insertor, forceps or manually. No specific technique has been found to be superior.

- ii) The strings of the IUD are trimmed at the level of the cervix (Pargard IUD strings will not need to be trimmed)
  - iii) Fundal massage may be performed per usual protocol. Try to avoid manually expressing the uterus of clots after the IUD is placed
9. Procedure for immediate postpartum insertion of the IUD following vaginal or cesarean delivery
- i) Patients should be offered a dose of their postpartum pain medication one hour before the time of insertion.
  - ii) The time of delivery should be confirmed by the provider prior to setting up for IUD placement.
  - iii) The provider ensures that an ultrasound is in the room for placement.
  - iv) The patient should void prior to the insertion process.
  - v) Placed the speculum or retractors prior to opening IUD (waiting until this point avoids opening the IUD until it is sure to be placed, so it is not wasted if unable to be placed for any reason).
  - vi) The provider sets up and inserts the IUD in the manner described above for immediate post-placental insertion following vaginal delivery.
  - vii) After the inserter or ring forceps have been removed, correct IUD placement is confirmed using ultrasound. If incorrectly positioned, adjustments can be made manually or with the ring forceps.
  - viii) The strings of the IUD are trimmed at the level of the cervix (Pargard IUD strings will not need to be trimmed).
10. Procedure for immediate post-placental IUD insertion after cesarean delivery:
- i) The cesarean delivery should be performed per routine practice of the operating physician(s) until delivery of the placenta. This includes administration of the usual prophylactic antibiotics and uterotonics (oxytocin, methylergonovine).
  - ii) Following routine care after delivery of the placenta (removal of membranes, control of bleeding, etc.), the circulating nurse opens the IUD with its inserter. Because it is packaged sterilely, the device and inserter can be placed directly on to the operating field. (Waiting until this point in the procedure avoids opening it until it is sure to be placed, so it is not wasted if unable to be placed for any reason).
  - iii) The levonorgestrel IUD strings will need to be trimmed (cut at the level of where they lock into the inserter) while the Copper IUD strings are not trimmed.
  - iv) Within 10 minutes of placental delivery, the IUD inserter is used to place the IUD at the fundus of the uterus. This is done in a similar fashion to standard transcervical insertion, however ultrasound guidance is not employed.
  - v) The IUD is placed using the inserter at the uterine fundus. The inserter is removed from the uterus.
  - vi) The assistant holds the IUD in place with a finger when the inserter is being removed, in order to ensure that the IUD stays at the fundus.
  - vii) The surgeon can place their non-dominant hand on the exterior of the fundus to stabilize the uterus and guide placement.

- viii) After the inserter has been removed, the assistant continues to hold the IUD in place with a finger and confirms correct placement (fundal and longitudinal) digitally. If incorrectly positioned, adjustments can be made manually.
  - ix) Careful attention should be paid when performing digital confirmation (and adjustment) such that removal of the finger or hand does not displace the IUD.
  - x) With the finger of the assistant *still* on the IUD at the fundus, IUD strings are then grasped at the distal tip with a ring forceps and inserted through the cervix into the vagina from above, via the hysterotomy site. The surgeon opens the ring forceps as much as possible before pulling back up through the cervix to avoid pulling the strings back up with it. The ring forceps should then be removed from the sterile field.
  - xi) The cesarean delivery should then be completed per the routine of the operating physician.
11. A note should be put in the patient's medical record in EPIC detailing the IUD insertion.
12. Documentation should include the lot number and expiration date of the device

## REFERENCES

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