

Example CLINICAL GUIDELINES for Postpartum IUD insertion

Postpartum Intrauterine Device Insertion

- 1.0 Indications:
 - 1.1 Insertion of an intrauterine device (IUD) for long-acting reversible contraception following vaginal or cesarean delivery.
- 2.0 Informed Consent:
 - 2.1 Proper informed consent must be obtained on a standard informed consent form.
 - 2.2 The patient should be counseled about the benefits, risks and contraindications of postpartum IUD insertion.
 - 2.2.1 Benefits include:
 - 2.2.1.1 Convenient setting for placement of IUD
 - 2.2.1.2 Less patient discomfort
 - 2.2.1.3 No need for a return visit for device insertion
 - 2.2.1.4 Verification that the patient is not pregnant
 - 2.2.1.5 Insurance coverage within postpartum period for many women
 - 2.2.2 Risks include:
 - 2.2.2.1 Bleeding
 - 2.2.2.2 Infection
 - 2.2.2.3 Perforation
 - 2.2.2.4 Higher expulsion rate (possibly as high as 25%)
 - 2.2.2.5 Possible increased cost if no insurance coverage for the device
 - 2.2.3 Contraindications include:
 - 2.2.3.1 Chorioamnionitis (defined as antibiotics given for fever/other symptoms in labor or post-delivery)
 - 2.2.3.2 Prolonged rupture of membranes
 - 2.2.3.3 Hemorrhage
 - 2.2.3.4 Uterine malformation
 - 2.2.3.5 Gynecological tumors
 - 2.2.3.6 Severe anemia
 - 2.2.3.7 Breast cancer (for the Mirena IUD)
 - 2.2.3.8 Pelvic tuberculosis
 - 2.2.4 Contraindications do NOT include:
 - 2.2.4.1 Delayed infection
 - 2.2.4.1.1 If the IUD has been placed, and she becomes febrile or has other signs of chorioamnionitis after placement, treat her with routine antibiotics if indicated
 - 2.2.4.1.2 The IUD should only be removed if she does not show clinical improvement after 48 hours of treatment
 - 2.2.4.2 Delayed hemorrhage
 - 2.2.4.2.1 Treat hemorrhage medically with uterotonics as indicated
 - 2.2.4.2.2 The IUD may have to be removed if D&C or Bakri balloon placement is indicated
 - 2.2.4.2.3 The IUD does not have to be removed in the setting of embolization
 - 2.2.5 Other considerations:
 - 2.2.5.1 Common need to trim strings postpartum

- 2.2.5.2 Missing strings more common
- 2.2.5.3 Risk of inability to place because of labor and delivery complications
- 2.2.6 Alternatives:
 - 2.2.6.1 Interval IUD insertion (greater than four weeks postpartum)
 - 2.2.6.2 Other methods of contraception
- 3.0 Provider Training:
 - 3.1 Providers must complete a training on postpartum IUD insertion and be signed off on the procedure by Dr. Katharine White.
 - 3.2 Training consists of:
 - 3.2.1 Watching an instructional video
 - 3.2.2 Hands-on experience with a uterine model
 - 3.2.3 Supervised insertion of one postpartum IUD
 - 3.2.3.1 Supervision may be by Dr. White or one of the residents signed off on postpartum IUD insertion
- 4.0 Equipment needed for IUD insertion:
 - 4.1 bivalve speculum
 - 4.2 sterile scopettes
 - 4.3 sterile scissors
 - 4.4 ring forceps for cervix stabilization (optional)
 - 4.5 ring or ovum forceps for IUD insertion (for Paragard; optional for Mirena)
 - 4.6 ultrasound
- 5.0 Procedure for immediate post-placental insertion during vaginal delivery
 - 5.1 The vaginal delivery should be performed per routine practice of the operating physician(s) until delivery of the placenta. This includes administration of the usual uterotonics (oxytocin, misoprostol).
 - 5.2 Following routine care after delivery of the placenta (removal of membranes, control of bleeding, etc.), the nurse opens the IUD with its inserter. Because it is packaged sterilely, the device and inserter can be placed directly on to the delivery tray. (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.)
 - 5.3 The provider places a bivalve speculum into the subject's vagina to expose the cervix.
 - 5.4 For Mirena insertion:
 - 5.4.1 The strings of the IUD are placed in the thread cleft in the usual fashion, and the strings are trimmed just above the cleft.
 - 5.4.2 The provider slides back the flange all the way to the handle.
 - 5.4.3 The inserter is passed into the lower uterine segment under ultrasound guidance, and the slider is pulled back until the top of the slider reaches the mark (raised horizontal line on the handle).
 - 5.4.4 The provider waits 10 seconds, then advances the inserter to the uterine fundus.
 - 5.4.5 The provider pulls the slider all the way back, releasing the Mirena at the fundus, then carefully removes the inserter from the uterus.
 - 5.4.6 The Mirena may also be inserted using ring or ovum forceps, as outlined below.
 - 5.5 For Paragard insertion:
 - 5.5.1 The provider removes the IUD from the inserter. The surgeon grasps the tail of the IUD with a ring or ovum forceps.
 - 5.5.2 The ring forceps are used to place the IUD at the fundus of the uterus under ultrasound guidance.

- 5.5.3 The ring forceps are opened, allowing the IUD to remain at the fundus, and they are carefully removed.
 - 5.5.4 The provider can place their non-dominant hand on the exterior of the fundus to stabilize the uterus and guide placement.
 - 5.5.5 After the 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.
 - 5.5.6 Careful attention should be paid when performing any adjustments that the IUD is not inadvertently removed.
 - 5.6 The strings of the IUD are trimmed at the level of the cervix.
 - 5.7 Uterine (abdominal) massage is permitted; do NOT manually express the uterus of clots after the IUD is placed. Uterotonics may be given as medically indicated.
- 6.0 Procedure for immediate post-placental insertion during cesarean delivery
- 6.1 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).
 - 6.2 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 sterile, 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.)
 - 6.3 For Mirena insertion:
 - 6.3.1 The strings of the IUD are placed in the thread cleft in the usual fashion, and the strings are trimmed just above the cleft.
 - 6.3.2 The inserter is used to place the IUD at the uterine fundus, in a similar fashion to standard transcervical insertion.
 - 6.3.2.1 The surgeon places tip of inserter at fundus via hysterotomy site; pulls back 2cm; moves blue notch (“slider”) on inserter handle back to mark on handle; waits for 10 sec; pushes inserter to fundus.
 - 6.3.2.2 The assistant places their finger on the IUD at the fundus and holds the IUD at the fundus until all insertion steps are complete.
 - 6.3.2.3 The surgeon then moves the blue notch on inserter all the way back to release strings, and finally removes inserter from uterus.
 - 6.3.2.4 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.
 - 6.3.2.5 The surgeon can place their non-dominant hand on the exterior of the fundus to stabilize the uterus and guide placement.
 - 6.3.3 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.
 - 6.3.3.1 Careful attention should be paid when performing digital confirmation (and adjustment) such that removal of the finger or hand does not displace the IUD.
 - 6.3.4 With the finger of the assistant *still* on the IUD at the fundus, the surgeon grasps the strings at the distal tip with a ring forceps and then inserts through the cervix into the vagina from above, via the hysterotomy site.
 - 6.3.5 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.
 - 6.4 For Paragard insertion:

- 6.4.1 The surgeon loads the IUD into the inserter per the usual method. The strings should not be trimmed.
 - 6.4.2 The inserter is used to place the IUD at the uterine fundus, in a similar fashion to standard transcervical insertion.
 - 6.4.2.1 The surgeon places the tip of the inserter at the fundus via hysterotomy site, then pulls back slightly.
 - 6.4.2.2 Holding the white rod, the insertion tube is pulled back, allowing deployment of the arms of the IUD.
 - 6.4.2.3 The assistant places their finger on the IUD at the fundus and holds the IUD at the fundus until all insertion steps are complete.
 - 6.4.2.4 The inserter tube and rod are removed from the uterus.
 - 6.4.2.5 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.
 - 6.4.2.6 The surgeon can place their non-dominant hand on the exterior of the fundus to stabilize the uterus and guide placement.
 - 6.4.3 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.
 - 6.4.3.1 Careful attention should be paid when performing digital confirmation (and adjustment) such that removal of the finger or hand does not displace the IUD.
 - 6.4.4 With the finger of the assistant *still* on the IUD at the fundus, the surgeon grasps the strings at the distal tip with a ring forceps and then inserts through the cervix into the vagina from above, via the hysterotomy site.
 - 6.4.5 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.
 - 6.5 The cesarean delivery should then be completed per the routine of the operating physician.
 - 6.6 Uterine (abdominal) massage is permitted; do NOT manually express the uterus of clots after the cesarean. Uterotonics may be given as medically indicated.
- 7.0 Procedure for delayed postpartum insertion of the IUD following vaginal or cesarean delivery
- 7.1 Patients should be offered a dose of their postpartum pain medication one hour before the time of insertion.
 - 7.2 The time of delivery should be confirmed by the provider prior to setting up for IUD placement.
 - 7.2.1 If placement of the IUD has not been *started* within 48 hours of delivery, it should **not** be placed.
 - 7.3 The patient should void prior to the insertion process.
 - 7.4 The provider confirms that the cervix is sufficient dilated for postpartum insertion:
 - 7.4.1 The surgeon places a bivalve speculum into the subject's vagina to expose the cervix.
 - 7.4.2 The ring forceps are placed into the cervix under ultrasound guidance to confirm cervical dilation.
 - 7.5 The provider sets up and inserts the IUD in the manner described above for immediate post-placental insertion following vaginal delivery.
 - 7.6 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.

- 7.6.1 Careful attention should be paid when performing any adjustments that the IUD is not inadvertently removed.
 - 7.7 The strings of the IUD are trimmed at the level of the cervix.
 - 7.8 Uterine (abdominal) massage is permitted; do NOT manually express the uterus after the IUD is placed. Uterotonics may be given as medically indicated.
- 8.0 Other Issues
- 8.1 Informed consent for IUD insertion should be obtained prior to the procedure.
 - 8.2 A notation in E&C Peribirth should be made documenting the IUD insertion.
 - 8.3 A note should be put in the patient's medical record in CIS detailing the IUD insertion. A precompleted note is available for use ("KW PP IUD insertion")
 - 8.4 Documentation should include the lot number and expiration date of the device.

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