

Example Clinical Guideline for Immediate Postpartum LARC Insertion

RATIONALE

Delay in contraceptive provision until the six week postpartum appointment can leave some women at risk for rapid repeat pregnancy. Data shows that 10-40% of women do not attend the postpartum visit and up to 75% of women who plan to use an IUD during their pregnancy never obtain it postpartum. In addition, about half of women have resumed sexual intercourse before their six week postpartum appointment when ovulation may have already occurred.

Immediate postpartum insertion of an IUD carries an increased risk of expulsion (10-27%). However, given the significant proportion of patients who plan for but never obtain an IUD, the benefit of immediate postpartum insertion outweighs this concern.

Both the American Congress of Obstetricians and Gynecologists and the Centers for Disease Control support efforts to increase the immediate postpartum insertion of LARC due to its ability to decrease short-interval pregnancies.

COUNSELING

- Patient should receive adequate antepartum counseling about risks, benefits, and alternatives to LARC contraception. Counseling should also address issues particular to postplacental 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). The patient should be counseled regarding signs of IUD expulsion and know to return to the clinic for alternative contraception. Upon arrival to labor and delivery, formal written consent should be reaffirmed and signed.

INCLUSION CRITERIA

- Patients with verified medical coverage for immediate postpartum LARC.
- Patient must have a negative test for gonorrhea/chlamydia during the index pregnancy if an IUD is to be inserted.

EXCLUSION CRITERIA FOR POSTPLACENTAL IUD

- a history of gonorrhea/chlamydia within the index pregnancy in patients desiring an IUD
- recent (within 3 months) or active uterine infection
- known abnormality of the uterine cavity
- intrapartum fever of $>38^{\circ}\text{C}$
- postpartum hemorrhage (greater than 500mL for vaginal delivery or $>1,000$ mL for cesarean delivery)
- retained placenta requiring manual removal or D+C
- puerperal sepsis
- rupture of membranes beyond 24 hours

EXCLUSION CRITERIA FOR ETONORGESTREL IMPLANT

- History of breast cancer
- Abnormal coagulation parameters

For specific questions regarding medical contraindications for IUD/implants refer to CDC Medical Eligibility Criteria:

https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1_appendix.htm

PROCEDURE

A. ETONORGESTREL IMPLANT

- Sign consent
- Device and 1% lidocaine must be ordered in EMR and postpartum nurse will obtain in Omnicel
- Gather insertion packet which should include
 - Iodine prep
 - 2 cc 1% lidocaine
 - sterile gloves
 - 4 x 4 gauze
 - steristrips
 - 25G 1.5 in needle
 - bandage
 - tape

- Perform TIME OUT
- Etonorgestrel implant can be inserted in usual fashion by a certified physician at any point during the hospital stay

B. INTRAUTERINE DEVICE

- IUD device should optimally be inserted within 10 minutes of placental expulsion
- Ultrasound guidance can be used as needed
- Prophylactic antibiotics are not routinely administered.
- Fundal massage can be performed as per usual protocol.
- Do not open until ready to insert
- If an epidural is not in place, insertion analgesia may be obtained with a single dose of a rapid onset iv opioid (such as fentanyl)
- Perform bimanual exam to determine uterine angle
- Prep cervix with iodine solution
- After uterine massage but before perineal repair change to new sterile gloves
- PERFORM TIME OUT

MANUAL TECHNIQUE

- Remove IUD from the inserter and place IUD between the index and middle fingers.
- Place the opposite hand on the abdomen to externally stabilize the uterus.
- To ensure fundal placement, the operator should feel the impact of the device against the fundus both internally and through the abdominal wall or use ultrasound guidance.
- As the internal hand is removed, rotate it about 15 degrees to avoid dislodging the IUD.

FORCEPS TECHNIQUE

- After removal of the placenta, gently grasp the cervix with a ring forceps
- The device should be even with the tip of the ring forceps. Take care not to clamp down the forceps to avoid crush injury to IUD. Try to avoid

touching the vaginal walls while using a ring forceps to place IUD at the uterine fundus while gently retracting on the cervix. Use your external hand to stabilize the uterus externally. Release the ring forceps and rotate about 45 degrees and laterally to avoid removing the IUD.

- Paragard strings are 12 cm and should not be visualized after insertion; if the strings are visible, the IUD may be too low and reinserted should be considered. The strings usually descend spontaneously through the cervix and can be trimmed at a follow-up visit. If fundal placement is confirmed and strings are seen, trim to the level of the cervix.

INSERTER TECHNIQUE

- Can be used for the levonorgestrel IUD. Place the IUD 2 cm from the fundus using the inserter, deploy the device as usual by pulling back on the green slider to the marked line. Wait 30 seconds for the arms to open and advance 2 cm. Pull back slider all the way, remove the inserter. Levonorgestrel IUD strings should also be trimmed to the level of the cervix.

CESAREAN DELIVERY PLACEMENT

- TIME OUT for insertion should be included within the cesarean delivery time out.
- Do not open until ready to insert.
- Cesarean delivery consent must include consent for intrauterine device placement
- For a copper IUD, place the IUD at the uterine fundus with a ring forceps manually. The copper IUD strings are not trimmed. The inserting provider places the IUD at the fundus via the hysterotomy.
- The levonorgestrel IUD strings may need to be trimmed prior to placement up to where the strings lock in the inserter. The levonorgestrel IUD inserter may be used at the time of the cesarean section.
- Correct placement is confirmed manually (fundal and longitudinal). The assistant should help to hold the IUD in place while the inserter uses the ring forceps to push the strings through the cervix. The ring forceps is handed off the sterile field. The hysterotomy is then closed taking care to not include the IUD strings in the closure. The cesarean section is then completed.

DOCUMENTATION

- The provider must document insertion and bill for the procedure only. The scanned consent should include the device information with the lot number and expiration date. The devices must be documented in the log binder.

FOLLOW UP

- The patient should follow up for device check and possible string trimming in 2 weeks. Missing strings are more common after immediate postpartum placement than after interval insertion and should be managed according to protocol. Patient should not rely on intrauterine device for contraception until IUD check is performed.

REFERENCES

Reference protocols

University of Colorado

(<http://www.astho.org/Post-placental-IUD-protocol-CO/>)

University of Illinois at Chicago

Immediate Postpartum Long-Acting Reversible Contraception. Committee Opinion No. 670. American Congress of Obstetricians and Gynecologists. Obstet and Gynecol Aug 2016.

The South Carolina Postpartum LARC Toolkit. Choosewell, January 2016,
http://www.choosewellsc.org/SC_Postpartum_LARC_Toolkit.pdf.

Long-Acting Reversible Contraception: A Hospital Based Initiative. ACOG District II.
http://cfweb.acog.org/district_ii/larc/

CDC. U.S. medical eligibility criteria for contraceptive use, 2010: adapted from the World Health Organization medical eligibility criteria for contraceptive use, 4th edition. MMWR 2010;59(No. RR-4).

ACOG Long-Acting Reversible Contraception (LARC) Program
<http://www.acog.org/LARCimmediatepostpartum>

Hospital Billing and Reimbursement for Immediate Postpartum Long-Acting Reversible Contraceptives Effective July 1, 2015. Illinois,
<https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150630a.aspx>.

SPIRES Post Partum IUD insertion training demonstration.

<https://www.youtube.com/watch?v=uMcTsf8XxQ>

CARDEA: Inserting LARC Immediately After Childbirth eLearning Course

<http://cardeaservices.articulate-online.com/3074094383>

Hofler LG, Cordes S, Cwiak CA, Goedken P, Jamieson DJ, Kottke M et al. Implementing immediate postpartum long-acting reversible contraception programs. Obstet Gynecol 2017; 129.