University of Florida Health – Jacksonville
Department of Obstetrics and Gynecology

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Department/Labor and Delivery Standard Operating Procedure

SUBJECT: Post-Placental IUD Insertion

1. Scope. The guidelines for this policy apply to all Labor and Delivery personnel.
2. Responsibility: All Labor and Delivery personnel
3. General.
4. **IUD INSERTION**
    a. Patients considering post-placental IUD insertion should receive patient education from a provider both at prenatal visits and upon admission to Labor and Delivery. After completion of appropriate counseling, patients identified as appropriate candidates for post-placental IUD insertion (including being insured by the appropriate payor- United Medicaid at this time) can be offered post-placental IUD insertion. If the patient desires post-placental IUD placement, this will be noted in the admission H&P and/or progress note. On admission, the IUD will be ordered from the inpatient pharmacy, and the IUD will be placed in the patient room for immediate access at the time of delivery. If no contraindications exist to post-placental IUD, the IUD will be placed within 10 minutes of placental delivery.
    b. Provider will order the IUD in EPIC at the time of admission and the IUD, along with the corresponding necessary instruments and supplies for the procedure, will be placed in a locked cart/cabinet the patient room until the time of insertion.
    c. IUD will be inserted according to ACOG/manufacturer's guidelines.
5. **IUD REMOVAL**
    a. The IUD can be removed at any time in the patient's menstrual cycle.

SUPERVISION FOR IUD COUNSELING AND INSERTIONS

1. Initiation of post-placental IUD insertion should be performed by a physician, certified nurse midwife, or nurse practitioner privileged for IUD insertion or OB/GYN resident physician with an appropriate degree of supervision as based on his/her experience and demonstrated competence.

COUNSELING FOR PARAGARD COPPER-T IUD OR PROGESTERONE IUD (MIRENA, LILETTA, SKYLA, KYLEENA)

1. Both the privileged clinician and any trainee involved should read and be familiar with readily available information on IUDs including (but not limited to) the following:

a. ACOG Practice Bulletin # 121: Long-Acting Reversible Contraception: Implants and Intrauterine Devices
b. ACOG Committee Opinion #670: Immediate Postpartum Long-Acting Reversible Contraception
c. ACOG Committee Opinion #672: Clinical Challenges of Long-Acting Reversible Contraceptive Methods
d. ACOG Committee Opinion #539: Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices
e. Eggebroten JL, Sanders JN, Turok DK. Immediate postpartum intrauterine device and implant program outcomes: a prospective analysis. Am J Obstet Gynecol 2017;volume:x.ex-x.ex.
f. Kaunitz, AM. Postpartum Contraception. In: UpToDate, Schreiber, CA (Ed), UpToDate, Waltham, MA.
g. Prescribing Information for the ParaGard IUD, Mirena IUD, Skyla IUDs, Liletta IUDs and Kyleena IUDs
h. Patient Information package inserts supplied with the IUD

2. A privileged clinician or appropriately supervised trainee must counsel the patient regarding all various contraceptive options (IUDs in particular) and answer all of the patient's questions about contraception. This counseling should include specific information pertaining to the increased risk of IUD expulsion and contraindications unique to post-placental placement.
3. The clinician and the patient should review together and sign a 'Patient Consent'.
4. It is also highly recommended to provide the patient with a copy of the patient information insert for future reference.

CONTRAINDICATIONS, WARNINGS, AND PRECAUTIONS

1. New research has refuted many of the long-standing contraindications for IUD use. Any questions about appropriate candidates should be referred to an experienced and up to date OB/GYN physician.
2. The following remain contraindications:
    a. Pregnancy, possibility of pregnancy, planned pregnancy in the next year
    b. Congenital or acquired uterine anomaly that distorts the uterine cavity (bicornuate uterus, fibroids which markedly distort the cavity)
    c. Acute PID, infected abortion, or postpartum endometritis within the last three months. Untreated acute cervicitis or vaginitis or other lower genital tract infection. It is not necessary to rule out GC or Chlamydia in asymptomatic women prior to insertion.
    d. In the setting of immediate postpartum IUD placement, contraindications include: intrauterine infection; postpartum hemorrhage; or puerperal sepsis.
    e. Unexplained abnormal uterine bleeding
    f. Acute liver disease or liver tumor (benign or malignant)
    g. Known or suspected breast cancer or other progestin-sensitive cancer
    h. Known or suspected uterine or cervical neoplasia (but not abnormal Pap smear or mild dysplasia)
    i. Hypersensitivity to any component of the IUD
3. These are NOT contraindications:
    a. Nulliparity
    b. Adolescents (WHO considers IUD acceptable anytime after menarche – Medical Eligibility Criteria 2). Adolescents and others at risk for STDs (< 26 y/o, promiscuity, prior STDs) should be screened for gonorrhea and Chlamydia. Screening can be done at the time of insertion since treatment with the IUD in place is usually sufficient.

c. Prior ectopic pregnancy or history PID > 3 months prior
d. Women who are not monogamous – IUD does not increase her risk of developing PID due to GC or Chlamydia (but the patient should be counseled on the importance of consistent condom use for STD prevention)
e. Breastfeeding
f. Abnormal Papanicolaou smear, once a colposcopy rules out severe dysplasia. (Patient does not need to be cleared from Colpo Clinic prior to IUD insertion – the clinician should however rule out need for LEEP as the goal would be to do the LEEP procedure prior to IUD insertion)

LOGISTICS FOR POSTPLACENTAL INSERTION OF THE IUD

1. IUD insertions are to be performed within 10 minutes of placental delivery in appropriately selected candidates after a patient has been counseled by a provider
2. It is not necessary in low risk patients to perform GC/CT cultures, await results of Pap smear, or give prophylactic antibiotics prior to IUD insertion.
3. Counseling is important for patient satisfaction and continuation. Patients with established care at UF Health clinics who are considering IUD for contraception should be counseled during prenatal care visits and appropriate documentation of this counseling should exist in the patient's medical record. Patients' desires can be confirmed at follow up visits and all questions answered during prenatal course.
4. In patients who were not identified and counseled during prenatal care (such as those with prenatal care at other facilities, no prenatal care, or those who have recently decided to use IUD for contraception), it is appropriate to insert the IUD immediately postpartum if counseling is completed, her decision is firm, there are no contraindications to the post-placental IUD insertion procedure, and the procedure is covered by her insurance payor.
5. If patient desires an IUD and is a candidate for post-placental insertion, this should be documented in admission H&P and intrapartum progress notes. Once identified, the IUD should be ordered using the L&D Postplacental IUD order set.
6. The IUD, which will be stored in the L&D Omnicell, will be pulled on admission and stored in a locked cart/cabinet in the patient room until the time of delivery. The corresponding necessary instruments and supplies for the procedure should also be obtained and placed in the locked cart/cabinet in the delivery room.
7. After delivery of the placenta, a pelvic examination should be performed prior to the IUD insertion to assess the uterine size and orientation in order to decrease the risk of uterine perforation or inappropriate insertions.
8. A pre-procedural 'time out' will be performed and documented in the medical record to confirm the appropriate patient, procedure, insurance payor, necessary supplies, and no contraindications.
9. The IUD must be placed within 10 minutes of placental delivery. Ultrasound guidance to confirm fundal placement is encouraged until all providers become proficient and comfortable with the procedure. IUD strings should be trimmed to 3-4 cm beyond external cervical os.
10. Clinicians are encouraged to review the brief insertion instructions provided in the IUD package insert prior to each insertion.
11. Premedication prior to the procedure is not necessary.
12. Patients do not require a backup method of contraception after post-placental placement unless expulsion is suspected or confirmed.

POST IUD INSERTION FOLLOW-UP

1. The patient should have a follow up clinic appointment in 2-3 weeks postpartum to document the presence of the IUD strings and trim them if necessary. This visit can also increase compliance by addressing the patient's questions and concerns about any side effects she may have experienced.
2. If IUD strings are unable to be visualized at the follow up appointment, a pelvic US should be performed to rule out IUD expulsion. If IUD expulsion is suspected, the patient should use a backup method of contraception until the IUD can be replaced (6 weeks postpartum).
3. The patient should have pelvic examinations annually thereafter.
4. The ParaGard IUD is approved for up to ten years of use; the Mirena and Kyleena IUD are approved for up to five years of use; and the Liletta and Skyla IUDs are approved for up to for three years of use. Removal and replacement can occur at the same visit.
5. Patient is instructed to call clinic immediately with concern for IUD expulsion, abdominal pain/cramping, fever/chills, or malodorous or purulent discharge.
6. These problems should always prompt immediate evaluation by a gynecologist:
    a. Infections
    b. Heavy bleeding
    c. Requests for removal
    d. Pregnancy
    e. Cannot find IUD strings
    f. IUD expulsion

Deanna C. McCullough, M.D., FACOG
Assistant Professor, OBGYN

Stephanie Tootle, M.D.
Resident Physician, PGY-3, OBGYN