FAQS IN OPTIMAL USE OF CURRENT LARC OPTIONS

Is there an increased incidence of pelvic inflammatory disease (PID) when using intrauterine devices (IUDs)?

In a study conducted by Sufrin and colleagues, the investigators confirmed that there is a low risk of PID after IUD insertion whether or not women have undergone prior screening for chlamydia or gonorrhea. The study also mentions that high-risk sexual behavior, and not methods of contraception, affects a patient's risk of developing PID.[1]

How should I manage PID in a patient with an IUD?

According to the Centers for Disease Control and Prevention's report on recommendations for contraceptive use, PID should be managed in the same fashion whether or not a woman has an IUD.[2] There is no need to remove the IUD, unless the patient insists on it. If the patient continues IUD use during treatment, follow up with the patient in 24 to 48 hours to evaluate the effectiveness of antibiotic treatment. If there has been no improvement, you can either continue the treatment or consider removal of the IUD and continue antibiotics. If the IUD is removed, remember to offer your patient another form of contraception until the PID is resolved.

What if the patient has an infection? Is it still safe to insert the IUD?

No. Placement of an IUD should be delayed in women who present with current purulent cervicitis or current chlamydial infection or gonorrhea until the course of treatment for the PID is completed.[2]

Are there any ways to manage or minimize the pain associated with IUD placement?

There are currently no effective treatments for reducing the pain experienced during IUD placement. A recent study did not show a reduction in pain scores associated with the use of nonsteroidal anti-inflammatory drugs (NSAIDs), cervical ripening agents, or intracervical lidocaine.[3] Another recent study on the use of 1% lidocaine paracervical block also did not show a significant decrease in perceived pain during IUD placement.[4] To help reduce patient discomfort, it is helpful to counsel her on the amount of pain she can expect to experience both
during the IUD placement and even a few days afterward. Preparing her for the procedure and reassuring her during IUD placement can also help lessen anxiety.[5]

**How soon after delivery, miscarriage, or abortion is it safe to place an IUD?**

An IUD can be inserted immediately following any of these events. Studies on placement of an IUD immediately after abortion or within 10 minutes of placental delivery were all shown to be safe, including placements that occurred following second-trimester abortions.[6,7] In fact, immediate postpartum IUD insertion was associated with lower expulsion rates vs later postpartum insertion.[6] An IUD should not be inserted in the setting of puerperal sepsis or immediately following a septic abortion.

**Can LARC be placed in teens without parental consent?**

Each state has its own laws on a minor's access to contraceptives. It is important for healthcare professionals to be familiar with the laws of their respective state. Please refer to [http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf) for state-specific information on provision of contraceptive services to minors.

**What are the contraindications to IUD placement?**

The United States Medical Eligibility Criteria for Contraceptive Use (US MEC) was created in 2010 to help guide healthcare professionals. There are 4 categories of medical eligibility criteria for contraceptive use, summarized as follows[2]:

- US MEC 1: no restriction
- US MEC 2: advantages generally outweigh theoretical or proven risks
- US MEC 3: theoretical or proven risks usually outweigh the advantages
- US MEC 4: unacceptable health risk

The following contraindications fall under US MEC 4: distorted uterine cavity, breast cancer for levonorgestrel IUD, insertion of IUD while awaiting treatment for cervical cancer, initiation with a diagnosis of endometrial cancer, gestational trophoblastic disease with persistently elevated beta-human chorionic gonadotropin levels or malignant disease, initiation with current PID, immediately following septic abortion, puerperal sepsis, pregnancy, initiation with current purulent cervicitis or chlamydial infection or gonorrhea, initiation with pelvic tuberculosis, initiation with unexplained vaginal bleeding that is suspicious for a serious condition.
How can I help my patient decide between Skyla® and Mirena®?

Both Skyla and Mirena are highly effective contraceptives that use the same progestin, levonorgestrel. The choice of IUD can be based on patient preference. Skyla is effective for 3 years, while Mirena can provide 5 years of protection against pregnancy. Bleeding irregularities may occur with both methods, especially in the first few months. Mirena is associated with lighter menses and some patients experience amenorrhea. Some patients prefer this, while others may find it “unnatural.” Some patients may want the monthly confirmation of lack of pregnancy provided by the menses. Amenorrhea is less common in women using Skyla, but Skyla is associated with irregular spotting, especially during the first 3 to 6 months of use. Providing this information, and finding out what the patient's expectations are is important in the decision-making process.

Are there specific recommendations for counseling adolescents about LARC?

Adolescents can use LARC successfully, as reported in the Choice Study, which involved participants as young as age 14. They should be informed that LARC methods do not protect against sexually transmitted infections. However, clinicians should be aware that an adolescent may present for LARC placement having no prior experience with pelvic examinations. According to recent guidelines from the American College of Obstetricians and Gynecologists, routine pelvic examinations and speculum examinations for cervical cancer screening should begin at age 21 unless medically indicated. If an adolescent chooses an implant rather than an IUD, she can continue to forgo pelvic examinations.

Are there any contraindication for IUDs if my patient has uterine abnormalities?

According to the US MEC, IUD placement is contraindicated for a patient with a distorted uterine cavity. Fibroids are not a contraindication as long as they do not cause a distortion of the uterine cavity or interfere with IUD placement.

References


2. Centers for Disease Control and Prevention. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. US Selected Practice Recommendations for Contraceptive Use, 2013: adapted from the World Health


