Decreasing Patient Anxiety During Routine Sexual + Reproductive Health Office Procedures

JOELY PRITZKER, RN, MS, FNP-C (SHE/HER)
VISTA COMMUNITY CLINIC

Introductions

Who am I?

Who are you?

Why are we here?

Learning Objectives

Describe 3 pre-procedure counseling topics for IUD and implant insertions

Explain what "verbicaine" is and how it can useful for in-clinic procedures

Identify evidence-based options for managing pain during IUD insertions

Demonstrate a provider/patient interaction regarding LARC removal visit

Disclosures

- Nothing to disclose

> “Patients of all ages are entitled to optimal comfort management before, during and after procedures and all health care providers have a responsibility to advocate and intervene to support the best interests of the patient…a procedure should be considered a biopsychosocial experience **for the patient** rather than simply a task to be completed by the health care providers.”

Position Statement from the American Society for Pain Management Nursing

(Czarnecki et al., 2011)

Research on Pain and Anxiety during Procedures

- Patients experience of pain is influenced by multiple factors
  - Age
  - Gender
  - Previous experiences
  - Pre-existing mental health conditions
  - Knowledge of procedure
  - Relationship with provider
- Anticipation of pain impacts the decision to seek care

(Czarnecki et al., 2011; Hoyo et al., 2005)

Research on Pain and Anxiety during Procedures (cont'd)

- IUDs
  - In studies related to IUC placement, fear of pain during the procedure can impact decision making around contraceptive options.
  - Anticipating patient's pain, especially in nulliparous patients, can lead some providers to discourage IUD use
  - Negative perception of IUDs and pre-procedural anxiety associated with higher pain during procedures
  - Providers tend to underestimate the patient's pain during a procedure
- Implants
  - Pre-procedural anxiety is common

(Murty, 2003; Brockmeyer, Kishen & Webb, 2008; Akdemir & Karadeniz, 2019; Maged et al., 2018; Callahan, Garabedian, Harney & DiVasta, 2019)

Why focus on the patient experience?

Ethical Considerations

- Informed Consent
- Minimize Traumatic Experiences for patients
- Legacy of reproductive coercion and forced sterilization, especially among communities of color & patients from lower SES background

Practical Considerations

- Better patient experiences
- Increased adherence with methods
- Decreased barriers to care

Common Procedures

- IUD Placements & Removals
- Hormonal Implant Placements & Removals
- Colposcopies & LEEPs
- In Clinic Abortions
- Endometrial Biopsies
- Vulvar Biopsies
- Genital Wart Treatments
- Bartholin Cyst I&Ds

Patient-Centered Language for Procedures

Medicalized

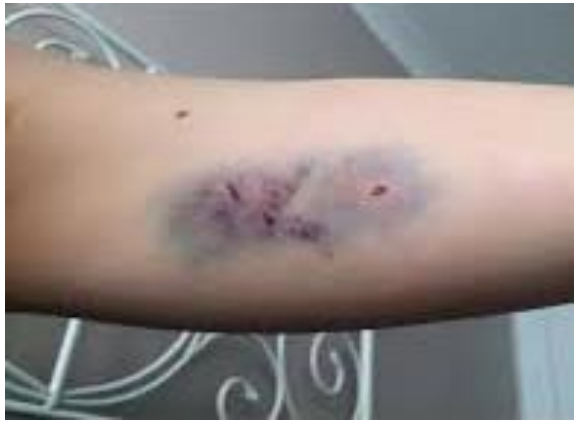
- Insert/Insertion
- LARC
- Relax
- Sound
- 98% efficacy
- Why?

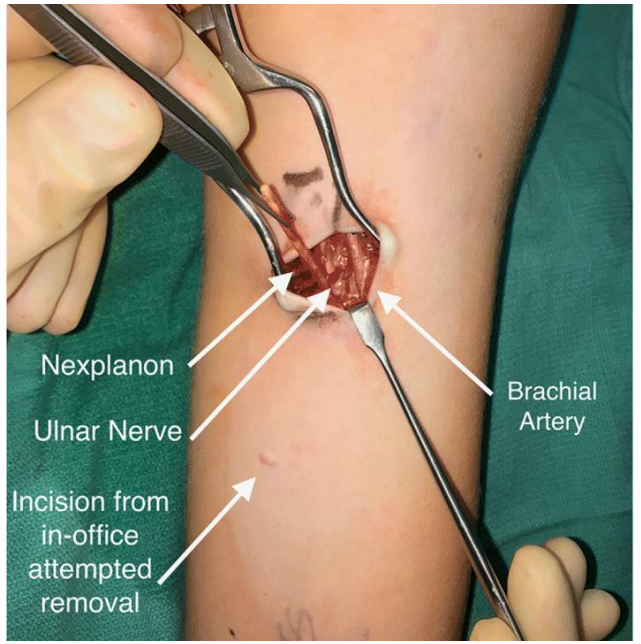
Patient-Centered

- Place/Placement
- Highly effective
- Soften, release
- Measure
- If 100 people used this method, only 2 might get pregnant.
- What?

("Language for IUDs and Implants (LARC)")

Hormonal Implants




Nexplanon
Ulnar Nerve
Incision from in-office attempted removal
Brachial Artery

Implant Pre-Procedure Counseling

Start with confirming the patient's desire for hormonal implant

"I see you're coming in today for the implant. What made you interested in that method?"

Assess how patient is feeling about the procedure

"How are you feeling about having an implant placed today?

Review relevant medical history, method highlights, procedure consent

"Let's go over a few things to make sure this is a safe method for you to use"

Start with confirming the patient's desire for hormonal implant

"I see you're coming in today for the implant. What made you interested in that method?"

- Opportunity to correct misinformation
  - "Actually, with the implant you probably won't be getting a regular period…"
- Counsel to the patient's knowledge level
- Establish Rapport

Assess how patient is feeling about the procedure

"How are you feeling about having an implant placed today?

- Opportunity to provide accurate reassurance
  - "For most people, the worst part is a little bit of numbing medicine. It's a burning, stinging feeling that lasts for about 10 seconds"
- Address patient's anxiety
- Allows patient to hear the rest of what you have to say

Review relevant medical history, method highlights, procedure consent

"Let's go over a few things to make sure this is a safe method for you to use"

- Use US MEC if needed
- Confirm information about expected bleeding patterns
- Reassurance regarding overall safety of method
  - Possibility of mild bruising, soreness after placement
  - Low risk of migration

Implant Placement Tips

- Distraction
  - Phone
  - Music
  - Friend/Partner in Room
  - Meditation
  - “Verbicaine”

Verbicaine

("Taking Your IUD Skills to the Next Level", n.d.;
"Contraceptive Pearl: Non-pharmacologic Pain Management", 2012)

Therapeutic conversation to support patients during procedures

Get patient talking about subject of interests—hobbies, kids, work

If desired, calmly describes steps of procedure; what they might be feeling

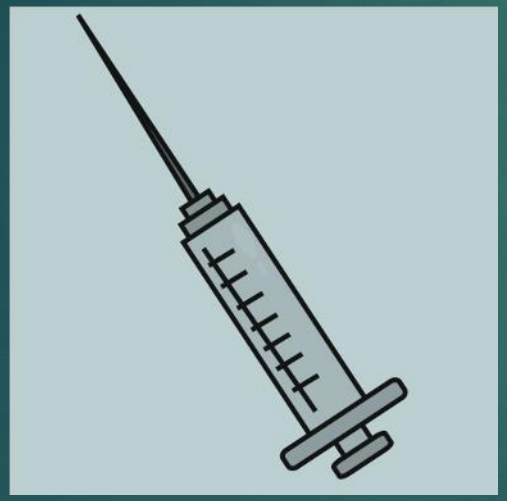
Use calming voice and slow pace

Verbicaine Practice

Implant Placement Tips

- If possible, draw up the lidocaine outside the room, especially if the patient is particularly anxious about needles
- Provide countdown until the end of the lidocaine injection; typically a 10 count works well
- Tell the patient when the lidocaine injection is done and remind them that the worst part for most people is done
- Reassure patient you are not going to place the implant until the patient's arm is sufficiently numb

Touch Test Before Implant Placement



- Wait about 90 seconds after lidocaine injection
- Ask patient to look away from arm
- Gently touch skin with sharp point of inserter
- Ask if patient feels something sharp or gentle pressure

Touch Test before Implant Placement

- Provides reassurance that arm is numb before placement
- Decreases patient anxiety that they will feel the implant being placed
- Often a moment of levity, especially if a friend or partner are in the room

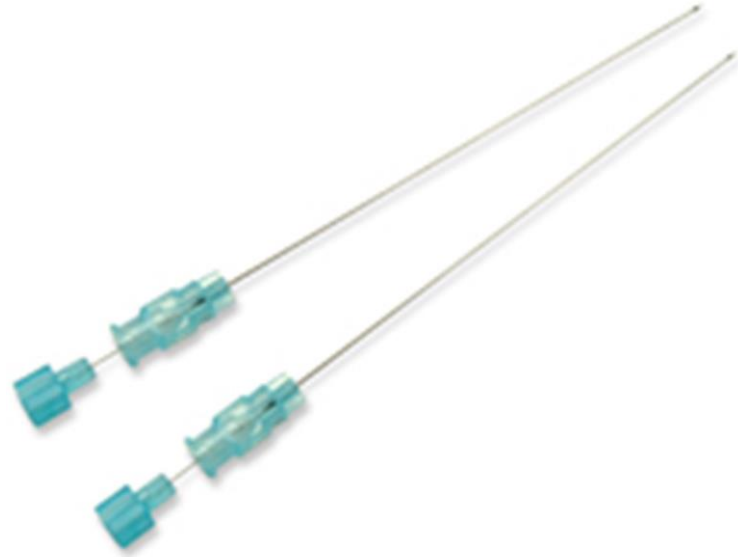
After Care Counseling for Implants

- Remind patient their arm will likely be bruised afterwards
- Pain medication not typically needed but Tylenol or NSAIDs may be used if arm is feeling sore
- When discussing warning signs, reassure patient that skin infections are very rare after implant placements
- Quick review of bleeding patterns (again!) and advise patient they may come in at any time to discuss side effects

Nexplanon Removal Tips

- Many of the approaches are the same as for placements
  - Check in with patient about how they are feeling about removal procedure
    - If they are feeling nervous or anxiety, reassure that most of the time incision is less than the size of a piece of rice
    - Remind them you will not make an incision until the arm is numb
    - Ask if they have looked at videos or pictures online
  - Verbicaine is very helpful
  - Use Touch Test (as with placements)
  - If removal is more difficult than anticipated, calmly let patient know that it may take a little more time

Procedures with Pelvic Exams



Trauma-Informed Pelvic Exams

- 1/5 women report that they had experienced a completed or attempted rape during their lifetime
- Negative experiences of pelvic exams are common
- Anticipation of pelvic exam may cause some patients to avoid seeking care

(Smith et al., 2019; Yanikkerem, Özdemir, Bingol, Tatar & Karadeniz, 2009)

Choosing the Right Words

Table NOT Bed

Hold NOT grasp

Drape NOT Sheet

Foot Rests NOT Stirrups

Let your knees fall out to the sides NOT Open your Legs

Preparing for a Procedure with a Pelvic Exam

- Remind patient they are in control and can stop the exam or procedure at any time
- Advise patient before each step of exam (no surprises)
- Patient comfort
  - Clothing
  - Distraction
- Positioning on table
  - One Slide Technique
- Speculum Placement
  - Use smallest (and shortest) speculum necessary
  - Lubricant
  - Gently move labial tissue to side
  - Apply posterior pressure to avoid urethra & clitoris
  - Use handle screw to increase visibility/working room if needed
- Keep supplies covered

("Trauma-Informed Pelvic Exam", 2015)

IUD Placements

IUD Pre-Procedure Counseling

Start with confirming the patient's desire for IUD

"I see you're coming in today for the hormonal/non-hormonal IUD. What made you interested in that method?"

Assess how patient is feeling about the procedure

"How are you feeling about having an IUD placed today?

Review relevant medical history, method highlights, procedure consent

"Let's go over a few things to make sure this is a safe method for you to use"

Start with confirming the patient's desire for hormonal implant

"I see you're coming in today for the hormonal/non-hormonal IUD. What made you interested in that method?"

- Opportunity to confirm hormonal vs non-hormonal, lower vs higher hormone IUDs
  - "How would it be for you to not get a period?"
  - Reinforce return to fertility after using method (if relevant)
- Counsel to the patient's knowledge level
- Establish Rapport

Assess how patient is feeling about the procedure

"How are you feeling about having an IUD placed today?

- Opportunity to provide accurate reassurance
  - "For most people, the placement is quite crampy and uncomfortable, like bad period cramps. I will let you know when you can expect to feel them. You can also let me know if at any point it is feeling like too much and we can stop or take a break."
- Address patient's anxiety
- Allows patient to hear the rest of what you have to say

Review relevant medical history, method highlights, procedure consent

"Let's go over a few things to make sure this is a safe method for you to use"

- Use US MEC if needed
- Confirm counseling about expected bleeding patterns
- Reassurance regarding overall safety of method
  - Review normal bleeding and cramping after placement
  - Low risk of perforation, infection, ectopic pregnancy

Pain Management During IUD Placements

WHAT WORKS?

IUD Pain Management Evidenced-Based Practices

- 2015 Cochrane Review looked at 33 trials with total of 5710 participants
- All RCT Trials
- Studies looked at pain at time of tenaculum placement, during IUC insertion, and after IUC insertion (up to six hours)
- Pain management methods included lidocaine, misoprostol, NSAIDs among others

Add citation for Cochrane Review

IUD Pain Management Evidenced-Based Practices (cont'd)

- PO Analgesics
  - Tramadol and Naproxen showed some effect on decreasing placement pain
  - Ibuprofen showed minimal impact on procedure pain
  - More effective for post-procedure cramping
- Lidocaine 1% paracervical block
  - Lowered pain with tenaculum placement
- Lidocaine 2% topical gel
  - No effect on tenaculum or placement pain
  - Some higher dose formulations of lidocaine gel (4%) may be effective
    - Time to take effect was 3-7 minutes
- Misoprostol
  - Higher pain scores than placebo
- Anxiolytics/Oral Sedation
  - Not routine practice. Typically reserved for special cases

(Lopez et al., 2015)

Verbicaine

("Taking Your IUD Skills to the Next Level", n.d.;
"Contraceptive Pearl: Non-pharmacologic Pain Management", 2012)

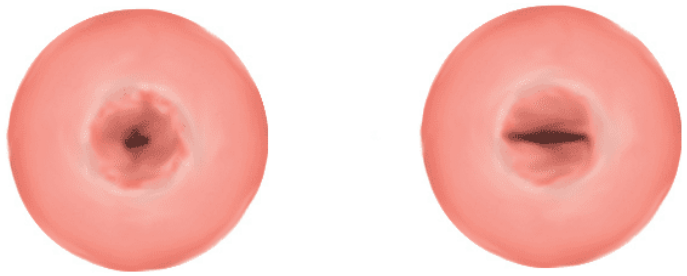
Therapeutic conversation to support patients during procedures

Get patient talking about subject of interests—hobbies, kids, work

If desired, calmly describes steps of procedure; what they might be feeling

Use calming voice and slow pace

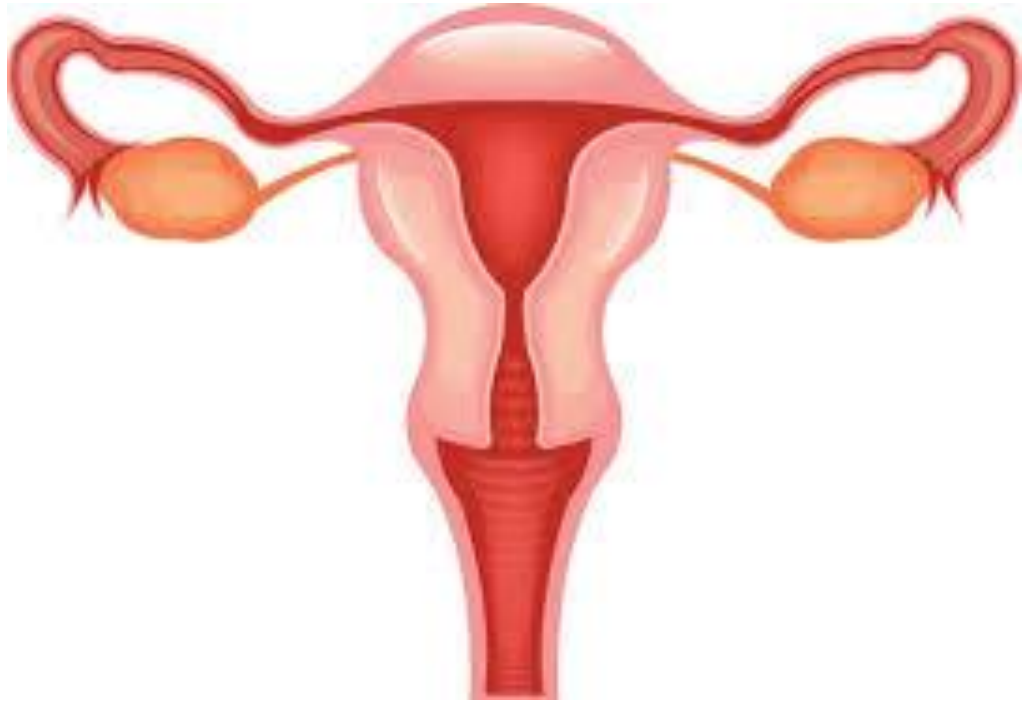
Tenaculum Placement



- Slow Placement
  - Count to 10 while placing tenaculum
- Close tenaculum quietly
- Dime-Sized grasp of cervix
- Remind patient they will likely feel a cramp
- Consider 1cc lidocaine 1% injection at 12 o'clock (for anterior placement) or 6 o'clock (for posterior placement) if needed
- Intentional movement of instrument
- Check in with patient after tenaculum placement

Uterine Sounding

- Advise patient this part may feel crampy and uncomfortable
- Use gentle, steady pressure if encountering resistance at internal or external os
  - Wrist (not arm motion)
  - 1-2-3 count (pause before proceeding to fundus)
- Remember bimanual exam and adjust direction of sound as needed
- Once you feel fundal resistance, tap fundus once—avoid repeated touching



Post-Procedure Care

- Tell patient not to get up right away and then get up slowly
  - Advise them to sit or lie down if they feel unsteady
- Offer menstrual pad (if available)
- Review NSAID use for cramping over next couple of days then PRN
- Reinforce normal to have cramping and irregular bleeding for first 3-6 months
  - Warning signs: cramping or pain that does not improve with NSAIDS; irregular discharge, fever
  - May return at any point if concerned about side effects or symptoms

Vasovagal Reactions

What is a vasovagal reaction?

How can we prevent them from happening?

Averting a Vasovagal

Recognize early signs and advise patient to tell you if they are feeling "off"

- Lightheadedness, dizziness
- Diaphoresis
- Yawning
- Blurred or reduced vision
- Feeling hot or cold
- Sudden need to urinate

Advise patient to tense hands, arms, legs and feet in isometric fashion

- Sample language: *"Tense up your muscles here, all of the muscles in your hands and arms and feet and legs—you don't need to move them at all—just grip your muscles really strongly. Now hold it...hold it."*

Repeat as needed

- Typically 1-2 times are sufficient
- May also use prophylactically for patient with known history

"How to Avert a Vasovagal Episode". (n.d.)

IUD & Implant Removals

Counseling Pearls

IUDs
Removal Time < Insertion Time; typically less painful

Implants
Removal Time > Insertion Time; similar pain from anesthetic

Timing of LARC removals

- There is an inherent power dynamic with LARC methods
  - Providers have the power to place these methods as well as hold the power to remove them
- Long history of reproductive coercion, especially among lower SES and minority groups
- Research documents that providers create barriers for LARC removals
- Need for a provider visit to discontinue method is sometimes a deterrent for patient to initiate IUDs or implants
- A patient ALWAYS has the right to request a removal, no matter how long they have been using the method

(Dehlendorf et al., 2018; Amico, Bennett, Karasz & Gold, 2016)

“the human right to maintain **personal bodily autonomy**, have children, not have children, and parent the children we have in safe and sustainable communities”

REPRODUCTIVCE JUSTICE

https://www.sistersong.net/reproductive-justice

LARCs & Reproductive Justice

Viewing contraception provision through a reproductive justice lens allows providers to keep the patient front and center in the visit

Considering the patient's individual needs allows the patient to be heard and minimizes anxiety or stress regarding respect for their reproductive autonomy

LARCs & Reproductive Justice (cont'd)

Pre-Placement Counseling

- At placement visit, remind patients that:
  - Methods work "up to" a certain amount of time and they can return AT ANY TIME to have the method removed
  - If they are having any issues with their method of choice you are there to help support them and troubleshoot as needed

Pre-Removal Counseling

- Gather information on what is motivating the desire for method removal
- Early in the conversation, confirm you can absolutely remove the method that day
- Ask permission to discuss possible solutions to problematic side effects/reasons for removal

Implant Removal Role Play

- Cynthia is 18 years old. She had the implant placed 2 months ago and is in clinic to have it removed.
- What comes up for you as a provider?
- How do you start the conversation?

Implant Removal Role Play (cont)

- Let's consider different scenarios
  - Unhappy with irregular bleeding
  - Likes method but broke up with partner and isn't planning on having sex
  - Had implant placed post-TAB. She now has a new partner and is thinking about pregnancy

Q&A

Works referenced and cited

- Akdemir, Y., & Karadeniz, M. (2019). The relationship between pain at IUD insertion and negative perceptions, anxiety and previous mode of delivery. *The European Journal Of Contraception & Reproductive Health Care*, *24*(3), 240-245. doi: 10.1080/13625187.2019.1610872
- Amico, J., Bennett, A., Karasz, A., & Gold, M. (2016). "She just told me to leave it": Women's experiences discussing early elective IUD removal. *Contraception*, *94*(4), 357-361. doi: 10.1016/j.contraception.2016.04.012
- Barr, W. (2006). Vaginal speculum examinations without stirrups. *BMJ*, *333*(7560), 158-159. doi: 10.1136/bmj.333.7560.158
- Brockmeyer, A., Kishen, M., & Webb, A. (2008). Experience of IUD/IUS insertions and clinical performance in nulliparous women–a pilot study. *The European Journal Of Contraception & Reproductive Health Care*, *13*(3), 248-254. doi: 10.1080/02699200802253706
- Callahan, D., Garabedian, L., Harney, K., & DiVasta, A. (2019). Will it Hurt? The Intrauterine Device Insertion Experience and Long-Term Acceptability Among Adolescents and Young Women. *Journal Of Pediatric And Adolescent Gynecology*, *32*(6), 615-621. doi: 10.1016/j.jpag.2019.08.004
- Cason, P., & Policar, M. *Taking Your IUD Skills to the Next Level*. Presentation.
- Contraceptive Pearl: Non-pharmacologic Pain Management. (2012). Retrieved 23 January 2020, from https://www.reproductiveaccess.org/resource/contraceptive-pearl-non-pharmacologic-pain-management/

Works referenced and cited (cont'd)

- Czarnecki, M., Turner, H., Collins, P., Doellman, D., Wrona, S., & Reynolds, J. (2011). Procedural Pain Management: A Position Statement with Clinical Practice Recommendations. *Pain Management Nursing*, *12*(2), 95-111. doi: 10.1016/j.pmn.2011.02.003
- Dehlendorf, C., Reed, R., Fox, E., Seidman, D., Hall, C., & Steinauer, J. (2018). Ensuring our research reflects our values: The role of family planning research in advancing reproductive autonomy. *Contraception*, *98*(1), 4-7. doi: 10.1016/j.contraception.2018.03.015
- Dehlendorf, C., Ruskin, R., Grumbach, K., Vittinghoff, E., Bibbins-Domingo, K., Schillinger, D., & Steinauer, J. (2010). Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *American Journal Of Obstetrics And Gynecology*, *203*(4), 319.e1-319.e8. doi: 10.1016/j.ajog.2010.05.009
- How to Avert a Vasovagal Episode. (n.d.). Retrieved January 20, 2020, from https://www.envisionsrh.com/how-to-avoid-vasovagal
- Hoyo, C., Yarnall, K., Skinner, C., Moorman, P., Sellers, D., & Reid, L. (2005). Pain predicts non-adherence to pap smear screening among middle-aged African American women. *Preventive Medicine*, *41*(2), 439-445. doi: 10.1016/j.ypmed.2004.11.021
- Ireland, L., & Allen, R. (2016). Pain Management for Gynecologic Procedures in the Office. *Obstetrical & Gynecological Survey*, *71*(2), 89-98. doi: 10.1097/ogx.0000000000000272

Works referenced and cited (cont'd)

- Lambert, T., Truong, T., & Gray, B. (2019). Pain perception with cervical tenaculum placement during intrauterine device insertion: a randomised controlled trial. *BMJ Sexual & Reproductive Health*, bmjsrh-2019-200376. doi: 10.1136/bmjsrh-2019-200376
- Language for IUDs and Implants. Retrieved 23 January 2020, from https://www.envisionsrh.com/language-for-iuds-or-implants
- Lopez, L., Bernholc, A., Zeng, Y., Allen, R., Bartz, D., O'Brien, P., & Hubacher, D. (2015). Interventions for pain with intrauterine device insertion. *Cochrane Database Of Systematic Reviews*. doi: 10.1002/14651858.cd007373.pub3
- Maged, A., Youssef, G., Eldaly, A., Omran, E., El Naggar, M., & Abdel Hak, A. et al. (2018). Benefits of vaginal misoprostol prior to IUD insertion in women with previous caesarean delivery: a randomised controlled trial. *The European Journal Of Contraception & Reproductive Health Care*, *23*(1), 32-37. doi: 10.1080/13625187.2018.1428297
- McCarthy, C. (2017). Intrauterine contraception insertion pain: nursing interventions to improve patient experience. *Journal Of Clinical Nursing*, *27*(1-2), 9-21. doi: 10.1111/jocn.13751
- Murty, J. (2003). Use and effectiveness of oral analgesia when fitting an intrauterine device. *Journal Of Family Planning And Reproductive Health Care*, *29*(3), 150-151. doi: 10.1783/147118903101197539
- Narayan, A., Sheeder, J., & Guiahi, M. (2018). Association of Anticipated Insertional Pain With Intrauterine Device Initiation. *Journal Of Adolescent Health*, *63*(1), 37-42. doi: 10.1016/j.jadohealth.2018.02.001

Works referenced and cited (cont'd)

- Reproductive Justice. Retrieved 23 January 2020, from https://www.sistersong.net/reproductive-justice
- Smith, S.G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Taylor, G., McDonagh, D., & Hansen, M. (2017). Improving the Pelvic Exam Experience: A Human-Centered Design Study. *The Design Journal*, *20*(sup1), S2348-S2362. doi: 10.1080/14606925.2017.1352750
- Trauma-Informed Pelvic Exam. (2015). Retrieved 23 January 2020, from https://www.reproductiveaccess.org/resource/trauma-informed-pelvic-exams/
- Yanikkerem, E., Özdemir, M., Bingol, H., Tatar, A., & Karadeniz, G. (2009). Women's attitudes and expectations regarding gynaecological examination. *Midwifery*, *25*(5), 500-508. doi: 10.1016/j.midw.2007.08.006