Advanced LARCs: Successful Management of IUD and Implant Challenges

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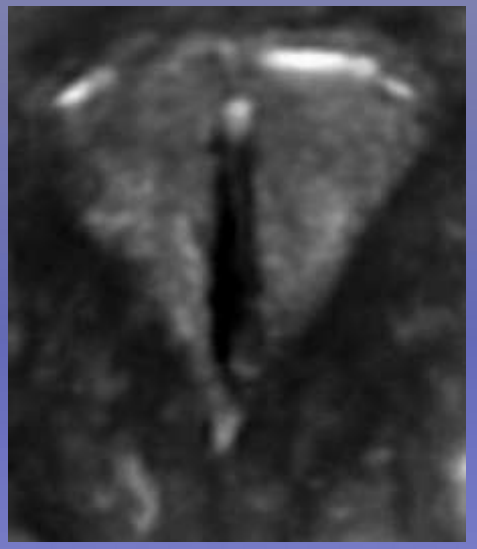


Objectives

- Demonstrate appropriate language for describing IUD complications when obtaining informed consent
- Display familiarity with use of the 2016 CDC guidelines
- Describe effective management of IUD related side effects.

Your Questions

"How can I assist my clinic with increasing the percentage of patients being asked about their contraceptive use?"

Reproductive Intention/Goals PATH Questions

1. Do you think you might like to have (more) children some day?
2. When do you think that might be?
3. How important is it to you to prevent pregnancy (until then)?

Counseling Patients Choosing a Contraceptive Method

Particular Characteristics Of Contraception

- Do you have a sense of what is important to you about your method?
- Do you have a sense of what you are looking for in a contraceptive method?

Elicit Her Attitudes About

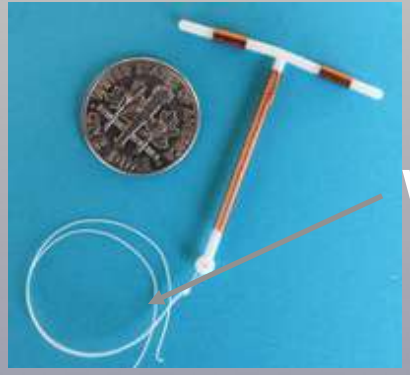
- Effectiveness
- Return to fertility
- Control over removal
- Menstrual cycle/bleeding profile
- Object in her body
- Non-contraceptive benefits
- Length of use
- Side effects
- Hormones

Your IUD Questions

- "To become aware of what providers might be dealing with"
- "Various types of IUD and Indications"

Copper: ParaGard

32mm horizontally x 36mm vertically



White threads

Levonorgestrel: LNG 52: Mirena

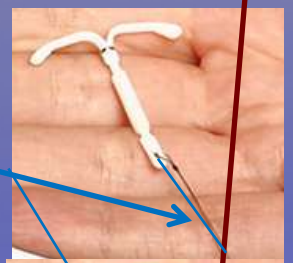
32mm x 32mm

Levonorgestrel: Liletta

32mm x 32mm

Blue threads

Brown threads



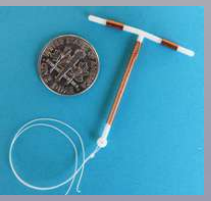
Levonorgestrel: LNG 19.5: Kyleena

28mm horizontally x 30mm vertically

Levonorgestrel: LNG 13.5: Skyla

28mm horizontally x 30mm vertically

Length of use “UP TO”



Copper: PARAGARD
12 years

Levonorgestrel: LNG 52: Mirena
5 (probably 7 years)

Levonorgestrel: Liletta
3 (probably 7) years

Levonorgestrel: LNG 19.5: Kyleena
5 years

Levonorgestrel: LNG 13.5: Skyla
3 years

Which LNG IUD

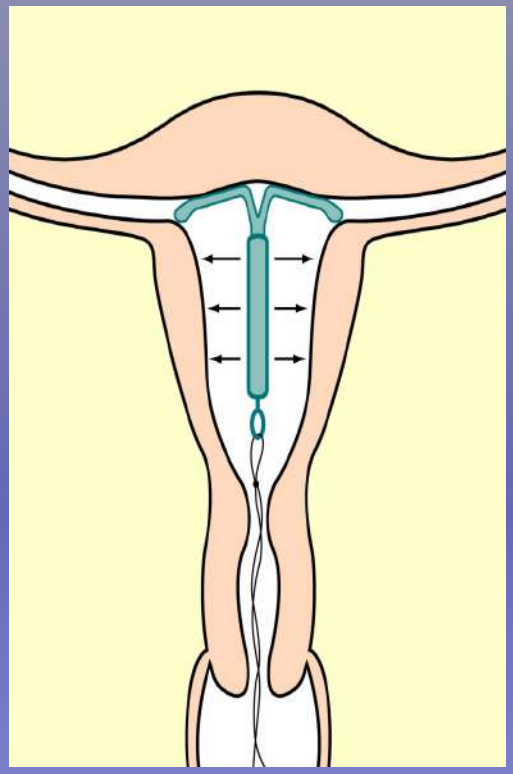
Brand Name	Skyla®	Kyleena®	Mirena®	Liletta®
LNG content (mg in reservoir)	13.5	19.5	52	52
Release rate (mcg/24 hrs) -- at end of life	14 5	17.5 7.4	20 +/- 10	19.5 17, 14.8, 12.9, 11.3, 9.8
Max duration, years	3	5	5 (7)	3 (7)
T-frame, mm	28 x 30	28 x 30	32 x 32	32 x 32
Insertion tube diameter	3.80	3.80	4.40	4.80
String color	Brown	Blue	Brown	Blue
Silver ring	Yes	Yes	No	No

Cu IUD: Mechanism of Action

- Primary mechanism is prevention of fertilization
  - Reduce motility and viability of sperm
  - Inhibit development of ova
- Possible secondary mechanism inhibition of implantation

LNG IUDs: Mechanism of Action

- Cervical mucus thickened
- Sperm motility and function inhibited
- Unlikely secondary mechanism of action
  - Endometrium suppressed
  - Occasional ovulation inhibition



Your IUD Questions

"Pre-insertion labs"

Pre-IUD placement Screening

- Pelvic exam
- No *routine* screening tests
  - Any indicated screening test can be performed at time of placement
- Baseline Hgb-may be helpful for later management

Pre-IUD placement Screening

- CT/GC:
  - –If age <25 and due for annual screening
  - –Or if high risk for STI
- Cervical cancer screening if due
- Pregnancy test if indicated

Copper T: Emergency Contraception

- Prospective, multicenter cohort clinical trial: 1,963 women in China; CuT380 placed within 120 hours of unprotected intercourse
- No pregnancies at 1 month follow-up visit
- 94% parous women and 88% nulliparous women continued at 1 year

Your Questions

"The challenges clinics face when managing patients IUDs"

"Why do so many fear getting them"

"General management of side effects of both the Implant and the IUDs."


MANAGEMENT

Responding to Complaints

- **All staff** gives similar messaging
- "Actively listen" to the complaint so you know the root problem!
- Then re-phrase
- She doesn't have to "fight for the right" to have her IUD removed
- Don't assume the visit is for removal

So you understand *what the real problem is* and

What outcome she wants:

Does Carol want…

- To be reassured that she is not in danger?
- The problem *fixed?*
- To complain? Be given compassion? Advice?

Any IUD: Cramping Pain and/or Spotting *Soon After Placement*

- It is normal for a woman to feel cramps, intermittent pelvic pain and any amount of spotting and light bleeding for a few weeks

- NSAIDS alleviate much or all of the cramping/pain

“I struggle with when to pull the trigger to get an ultra sound for cramping and discomfort.”

Expulsion
Perforation
Pregnancy
Infection

- Afebrile
- Negative pregnancy test
- Strings visible at the cervical os
- No mucopurulent discharge from the cervical os
- Normal bimanual exam – no cervical motion tenderness

Carol 18 year old G_2 P_2 In Medical Assistant School

- LNg IUD 52mg placed 2 months ago
- "I love my IUD but I spot almost every day and it is starting to make me crazy!"
- "You told me I might have spotting or irregular bleeding but this seems like it's not good for me."

LNG IUD: Unscheduled Bleeding

- Some women have irregular bleeding for 3-4 months after placement:
  - Frequent spotting
  - Frequent light bleeding
  - *Rarely* heavier bleeding
  - Usually resolves after 3-4 months
- General pattern: amenorrhea or regular menses get increasingly lighter with time

Empathy Without Labeling

- Rather than…
  - "You sound anxious" or "angry"
- Use neutral words…
  - "It sounds like this constant spotting is quite concerning to you"
  - "I can see that spotting every day is really hard to deal with"

Empathy Traps

Avoid…

- Saying, "I know what you mean"
- Downplaying the significance of the concern or side effect

Rather…

"In the first few months using this IUD many of my patients feel that way"

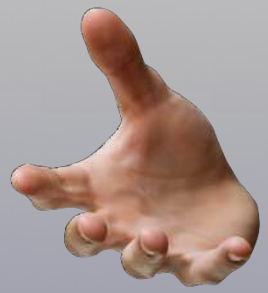
"Anyone would find that spotting to be a drag!"

Implant and LNG IUD Complaints Other than Bleeding

- Depends on the amount of progestin systemically absorbed
  - Weight gain, mood changes, acne, hair loss, headache
- Rarely
  - Breast tenderness and nausea

Susan G_1P_2 (twins)
29 year old Yoga Instructor

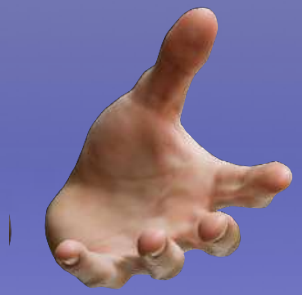
- Cu T placed 3 months ago
- "I love the fact that I am off hormones, but my periods are off the hook!"
- "I heard that this thing makes you bleed more and it sure does…"



On the One Hand-
On the Other Hand

"So it sounds like on one hand you would like to continue with your IUD…

"And on the other hand, your periods are really an issue right now. Do I have that right?"



pause for a reply

"Is there an NSAID that is more preferable to use for the spotting, or do all the NSAIDS (Naproxen vs Ibuprofen) have about the same effectiveness at reducing spotting? And what would be the doses you recommend, and for how long?"

Longer or Heavier Menses

NSAIDs prophylactically WITH FOOD

- Pre-emptive use for 1st 3 cycles
- Start before onset of menses
  - **Naproxen sodium 220mg x2 BID (max 1100mg/d)**
  - Ibuprofen 600-800mg TID (max 2400mg/day)

No Suppression of Endogenous Hormones with the Copper IUD

- May experience sensations related to her own endogenous hormones
  - –Premenstrual bloating, breast pain, tenderness, or swelling, mood changes, low back pain, dysphoria or depression
- Sharp brief stabbing pain during the time of ovulation

Your Questions about Unacceptable Bleeding

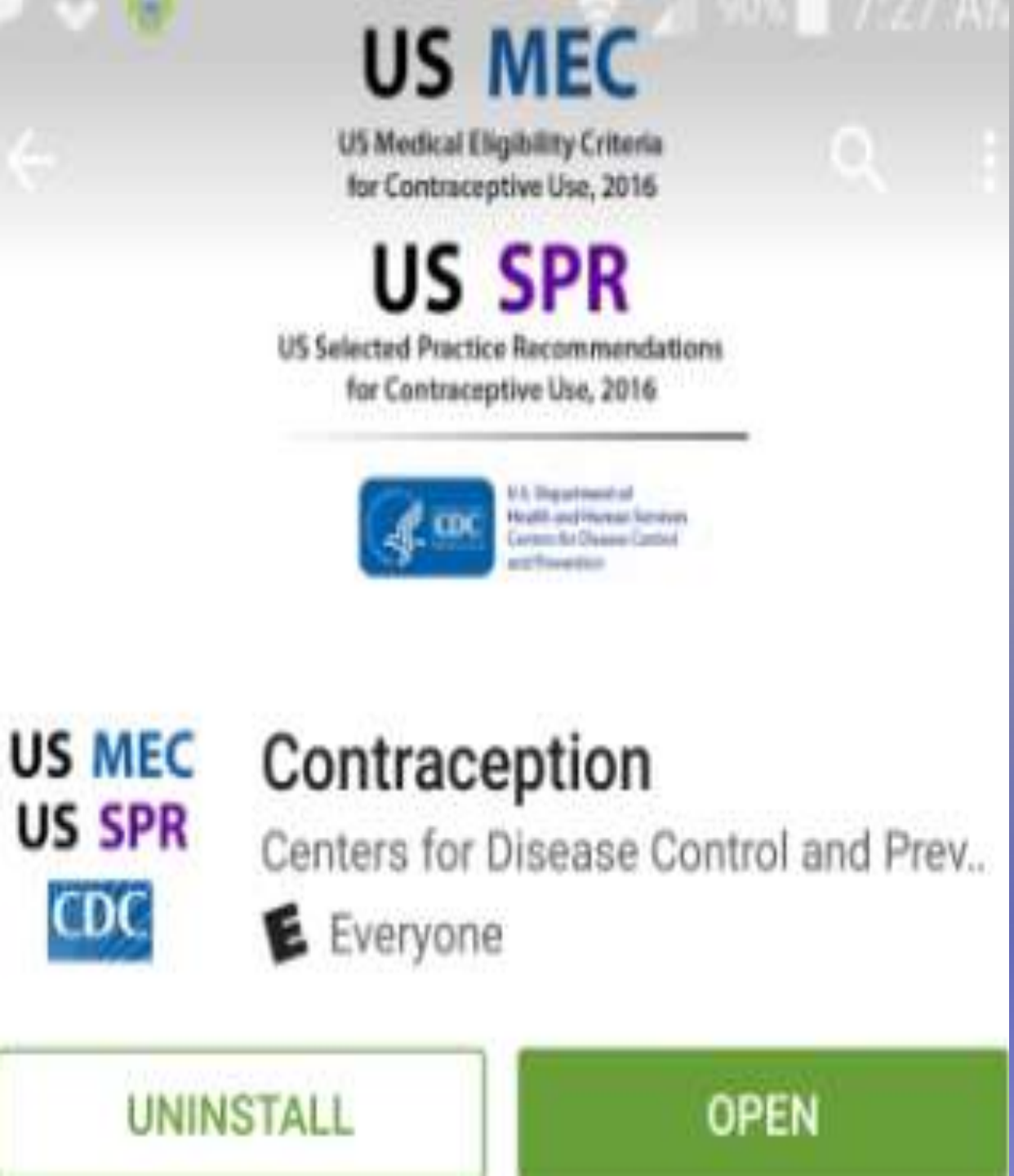
"Main thing I'm interested in is how to manage the Break through Bleeding many people have with the Nexplanon."

"What do I do for the woman who continues to bleed when using Nexplanon, after trying some "feedback estrogen" ? - That's OK as long as she is on the estrogen but the minute she stops the estrogen she's back bleeding again. And I've also tried Ibuprofen 600 mg BID with the same results. OK as long as she is on it but the minute she stops – she's bleeding again. "

“I see a lot of unwanted spotting on the Implant and have seen several different methods of giving OCPs - one is to have the patient take a pill every day until the bleeding stops and then an additional 5 more days. The other way I have seen is to have the patient take a full pack of pills and take the placebo pills to have a period, then only restart a second pack if the spotting continues...”

US Medical Eligibility Criteria 2016

Category	Definition	Recommendation
1	No restriction in contraceptive use	Use the method
2	Advantages generally outweigh theoretical or proven risks	More than usual follow-up needed
3	Theoretical or proven risks outweigh advantages of the method	Clinical judgment that this patient can safely use
4	The condition represents an unacceptable health risk if the method is used	Do not use the method



2016 CDC MEC and SPR phone app

If bleeding persists, or if the woman requests it, medical treatment can be considered.*

- **Cu-IUD users**
  - For unscheduled spotting or light bleeding or for heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
- **LNG-IUD users†**
- **Implant users†**
  - For unscheduled spotting or light bleeding or heavy/prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
- **Injectable (DMPA) users**
  - For unscheduled spotting or light bleeding:
    - NSAIDs (5–7 days of treatment)
  - For heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
- **CHC users (extended or continuous regimen)**
  - Hormone-free interval for 3–4 consecutive days
    - Not recommended during the first 21 days of extended or continuous CHC use
    - Not recommended more than once per month because contraceptive effectiveness might be reduced

If bleeding disorder persists or woman finds it unacceptable

Counsel on alternative methods and offer another method, if desired.

United States Selected Practice Recommendations for Contraceptive Use

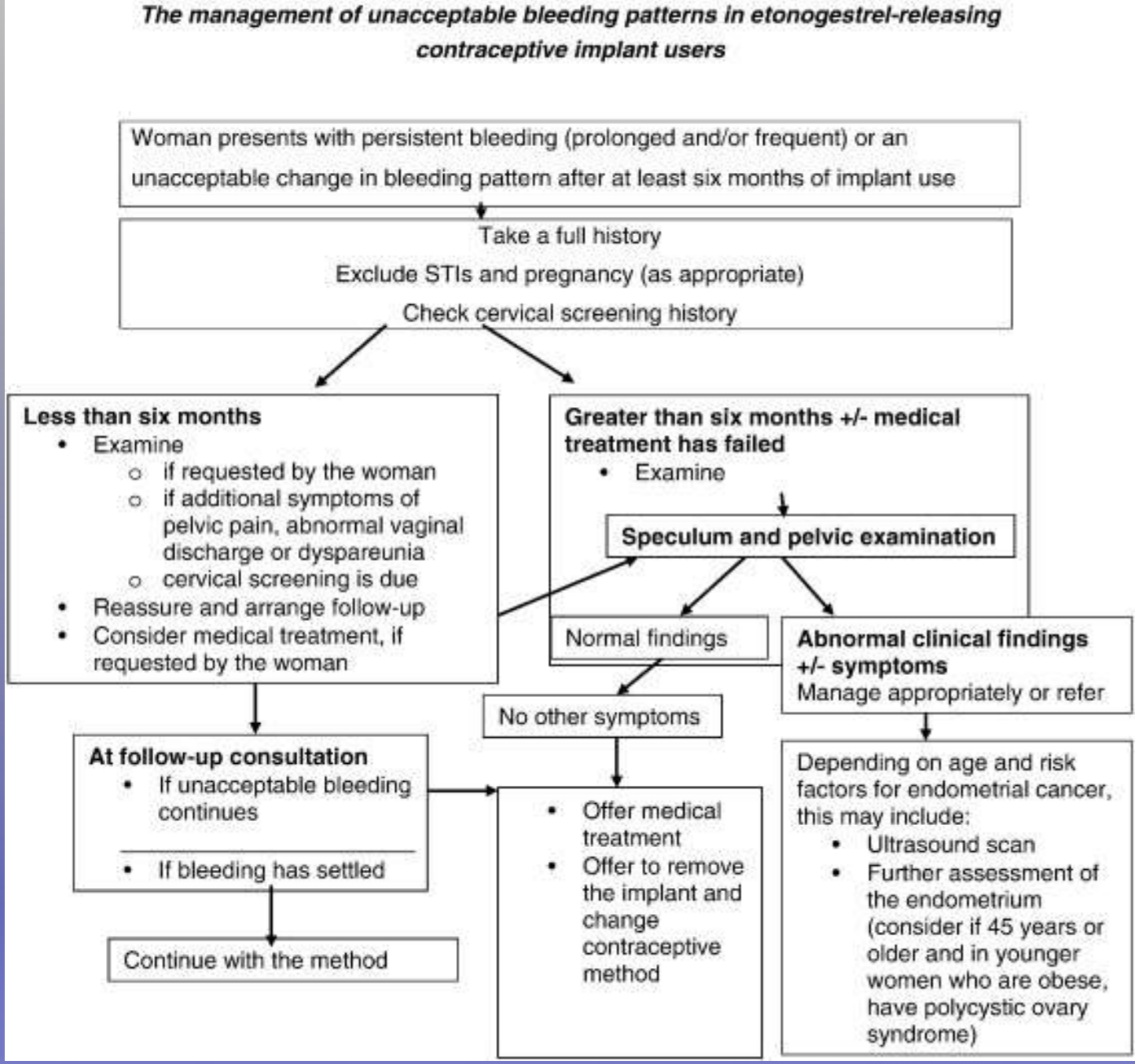
US SPR

Alternatives

- Tranexamic acid*
  - 250 mg QID x 5d
  - 500mg BID x 5d
  - 500md TID until bleeding resolves
- Progestin-only pill
  - Continuous use

*Lysteda

Fig. 1. Management pathway for ENG implant users with persistent vaginal bleeding (based on the UK's Clinical Effectiveness Unit, Faculty of Sexual and Reproductive Health Care guidelines 2009 [33]).



Mansour, D., Bahamondes, L., Critchley, H., Darney, P., & Fraser, I. S. (2011). The management of unacceptable bleeding patterns in etonogestrel-releasing contraceptive implant users. *Contraception, 83*(3), 202-210.

- What was her bleeding pattern both before and currently?
- How many bleeding days is she having per month?
- If she is using a non-LARC method, such as POPs or DMPA, is she using it correctly?
- Is her bleeding heavy or light?
- Is she having regular/irregular cycles or is the bleeding intermenstrual?

- Is she taking any other medications (ie, antiepileptic drugs, St John's Wort) that could interact with her contraceptive and therefore affect her bleeding?
- Are there any symptoms that are associated with her bleeding (ie, pain, nausea, vomiting, breast tenderness)?
- Does the bleeding occur at specific times (ie, after sex)?

Drug interactions

Drugs that may decrease the implant's effectiveness		
Barbiturates	Griseofulvin	St. John's wort
Bosentan	Oxcarbazepine	Topiramate
Carbamazepine	Phenytoin	Efavirenz
Felbamate	Rifampin	
Drugs whose plasma concentrations may change because of the implant		
Cyclosporin (increased)	Lamotrigine (decreased)	

"pop-out" or "fingers-only" Implant Removal Technique

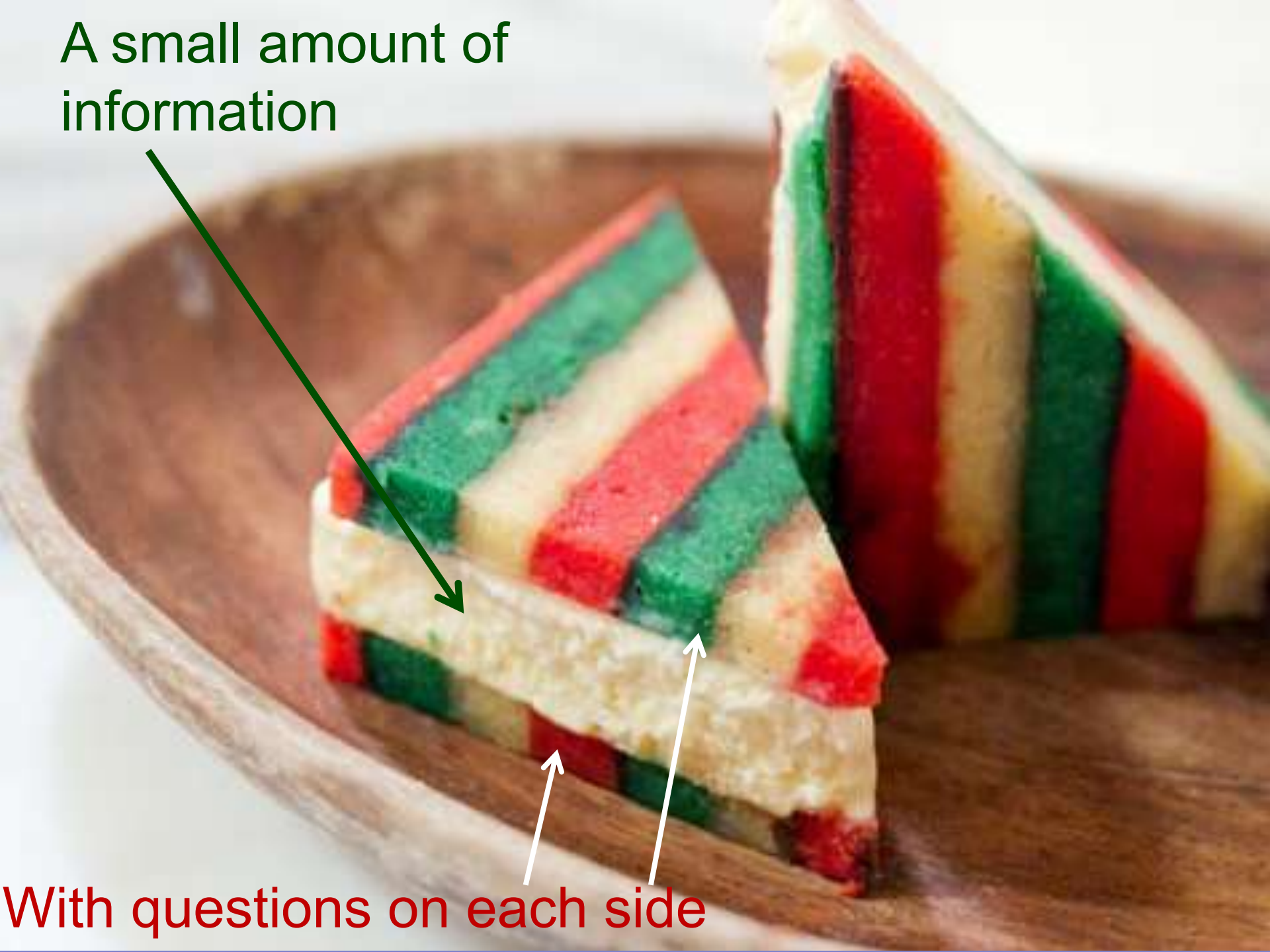
https://www.screenr.com/MS7N

Your Questions

"Patient education"

Language for LARC

"This method is good for **up to** _____ years but if you want to get pregnant before then or you would like it removed for any reason, come in, we will remove it and your ability to get pregnant will return *to whatever is normal for you immediately*."


A small amount of information
With questions on each side

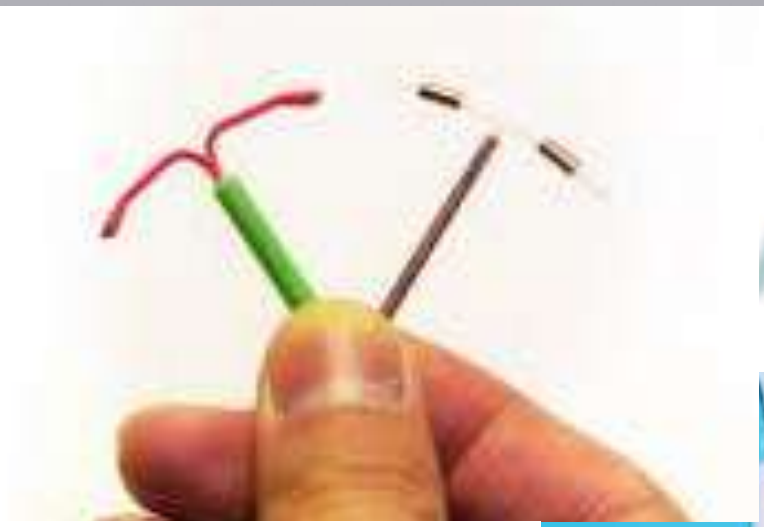
Questions for the Information Sandwich

- How would that be for you?
- Knowing that how would it be for you…?
- Has it ever happened before?
- How did you manage it?
- Do you have a sense of how you would manage it?

Demo Unit IUDs and Implant

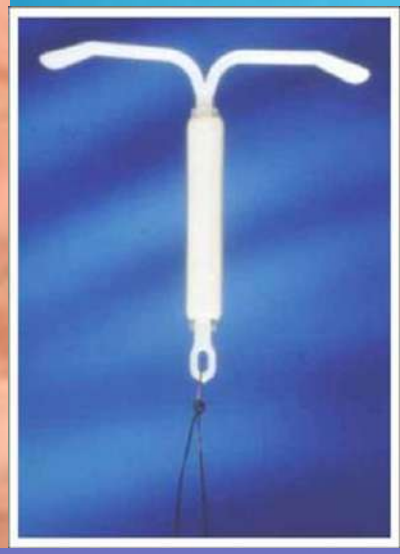
Give them the unit to hold, feel and play with while discussing the method

- how to feel the threads
- what the plastic feels like if it is expelling







Informed Consent

- Discuss menstrual changes
- Perforation, infection, expulsion, method failure
- Return if
  - String cannot be located
  - Symptoms of pregnancy/infection
  - Sudden unexplained pelvic pain or dyspareunia occurs
  - Excessively heavy bleeding

Symptom	Possible Explanation
Pain or dyspareunia	Infection, perforation, partial expulsion
Missed period, other signs of pregnancy, expulsion	Pregnancy (uterine or ectopic)
Shorter, longer, or missing threads	Partial or complete expulsion, perforation

Responding to "Unfounded" Concerns

"That's too bad your friend had that experience. I haven't heard of that before, and I can tell you it definitely doesn't happen frequently."

Try NOT to Disagree

- Whenever possible, find something in what she is saying to agree with and then add your scientific or medical information.

- "Yes! …. and…" Instead of "No" or "But"

Advanced Clinical Content

Pain prevention with use of tenaculum and sound

Perforation prevention

Visualizing cervix with patients who are obese

Difficulty getting through internal os

Pain prevention- verbicaine

Complications

Preventing a vasovagal

Missing strings

Pregnancy with IUD in place

Tenaculum Pain Prevention

- Only click to first or second ratchet
- Close the tenaculum very, very slowly
- Close the ratchet *silently*
- Take a bite no larger than you need

Tenaculum Pain Prevention

- 1cc Local anesthetic to tenaculum site
- Have patient cough (…hold onto the speculum)
- Don’t move the tenaculum inadvertently
- During sounding and IUD placement, don’t hook your fingers through the rings

Uterine Sound: Which One?

- Metal sound
- Plastic sound
- Endometrial sampler
- Two sided dilator

Uterine Sound Pain Reduction

- Touch the fundus once
  - Repeated tapping is unnecessarily uncomfortable for the patient
- Move slowly and intentionally
  - Moving too quickly increases discomfort

Uterine Sound

- If metal; bend sound to mimic uterine flexion
- Hold it like a pencil or dart
- Use *Wrist* action
- Brace fingertips on speculum to achieve control of force while advancing the sound

Uterine Sound: *S-l-o-w* Progression

- Through the internal os
- *Pause once you have passed through the internal os*
- Slow intentional progression to the fundus

Obesity: Bimanual Exam

- It may be difficult or impossible to palpate the uterus or ovaries
- Place the abdominal hand UNDER the panniculus to decrease amount of adipose tissue between the hand and the uterus
- Pelvic sonogram if sounding difficult

Obesity: Have Appropriate Instruments in the Room

- Specula of varying sizes
- Ensure adequate lighting
- Tongue blades or retractors or ring forceps
  - Use closed ring forceps or tongue blade to gently push vaginal walls to the side to improve visibility

Obesity: The Right Speculum

- Too narrow--will not allow for good visualization
- Increase *width rather than length*
  - Avoid a long speculum
  - It can firmly splint the cervix in place
  - Does not allow you adequate cervical mobility to straighten the uterine flexion when using a tenaculum

Open the speculum blades at the base as well as the tip

Optimize Position

- Position Sarah as far down on the exam table as possible to allow maneuvering of the speculum once in place

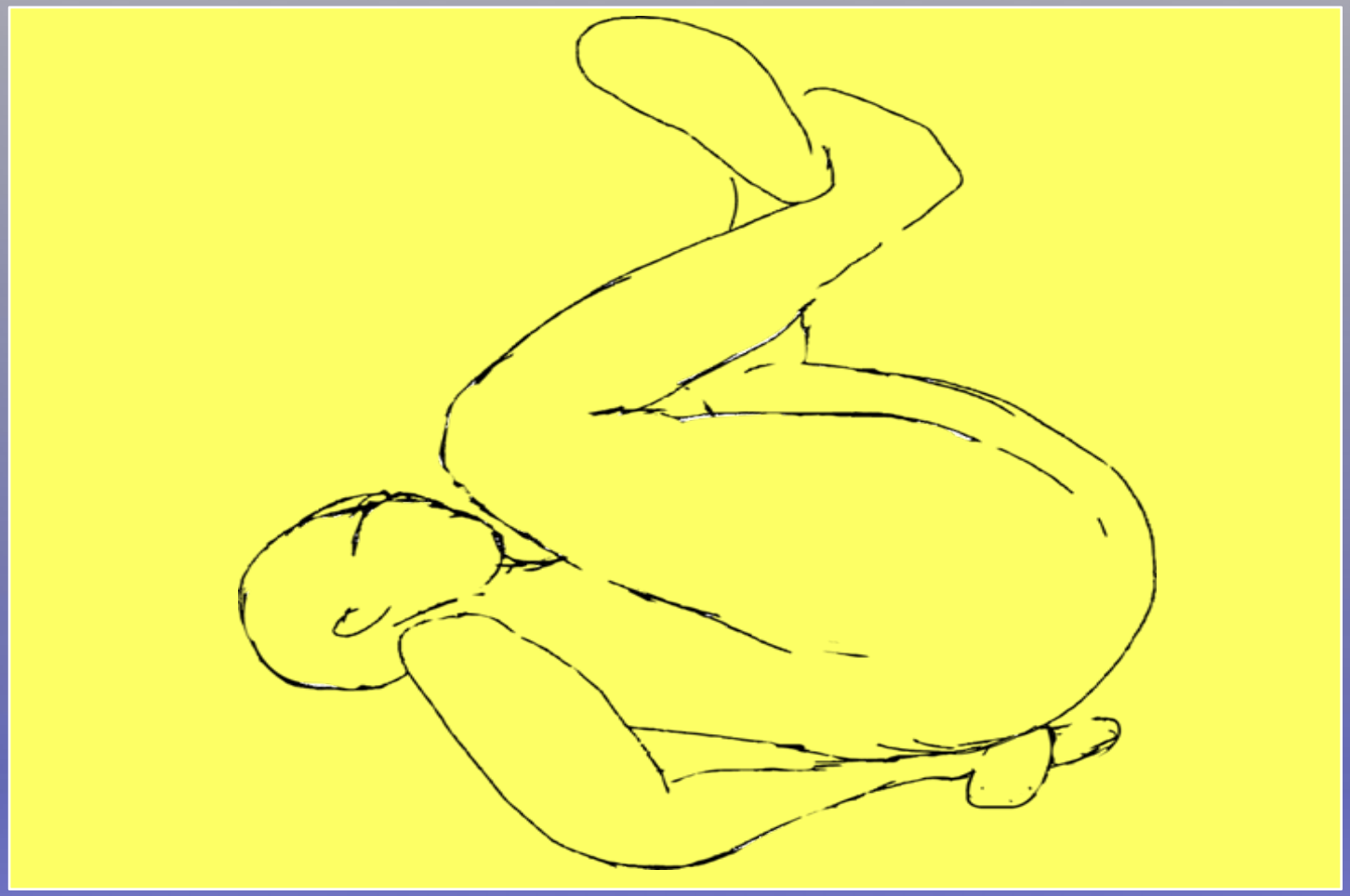
- Hips over the edge of the exam table drops her pelvis and cervix forward and makes visualization easier

Optimize Position

Raise her buttocks…

- Have her place her hands in a fist under her own buttocks
- Lower the head of the table
- Place a lift under her buttocks

“Cannon Ball” Or “Knees To Chest”



She pulls her knees up and back

Mary 18 Year Old G_0 P_0

"I Am So Afraid to Have This Done!"

- Will this hurt?

Outpatient Procedure Pain Relief Principles And Application

- Verbicaine
- Slow technique
- Oral sedation
- Tenaculum site local anesthetic
- Controversies
  - Pre-insertion NSAIDs
  - Pre-insertion misoprostol
- Paracervical and intracervical block

Verbicaine

- Keep her talking!
- Calm, soothing vocal tone
- Slow, easy pace

- Utilize whatever works for the patient
  - Breathing techniques
  - Mindful mediation
  - Guided imagery

Distraction

Non-Steroidal Anti-inflammatory Drugs

Cochrane review, 2015

- Tramadol and naproxen had some effect on reducing IUD insertion pain in specific groups
- Lidocaine 2% gel, misoprostol, and most NSAIDs did not help reduce pain

- Conventional wisdom
  - Rx naproxen sodium 550 mg or Ibuprofen 800 mg
  - Helps mainly with post-insertional cramping

Lopez LM et al. Interventions for pain with IUD insertion. Cochrane Database of Systematic Reviews 2015, Issue 7. Art. No.: CD007373

Difficult IUD Placements

Kristin 29 year old G_0
In the office for a LNg IUD

- On DMPA for the last 3 years
- LEEP for CIN 3 at age 25; negative cytology since

- Tenaculum applied, but the clinician is unable to pass a metal sound

What would you recommend?

Tenaculum

1. Change the amount of traction

2. Apply traction in different direction

At what point would you recommend or offer a block?

Uterine Sound

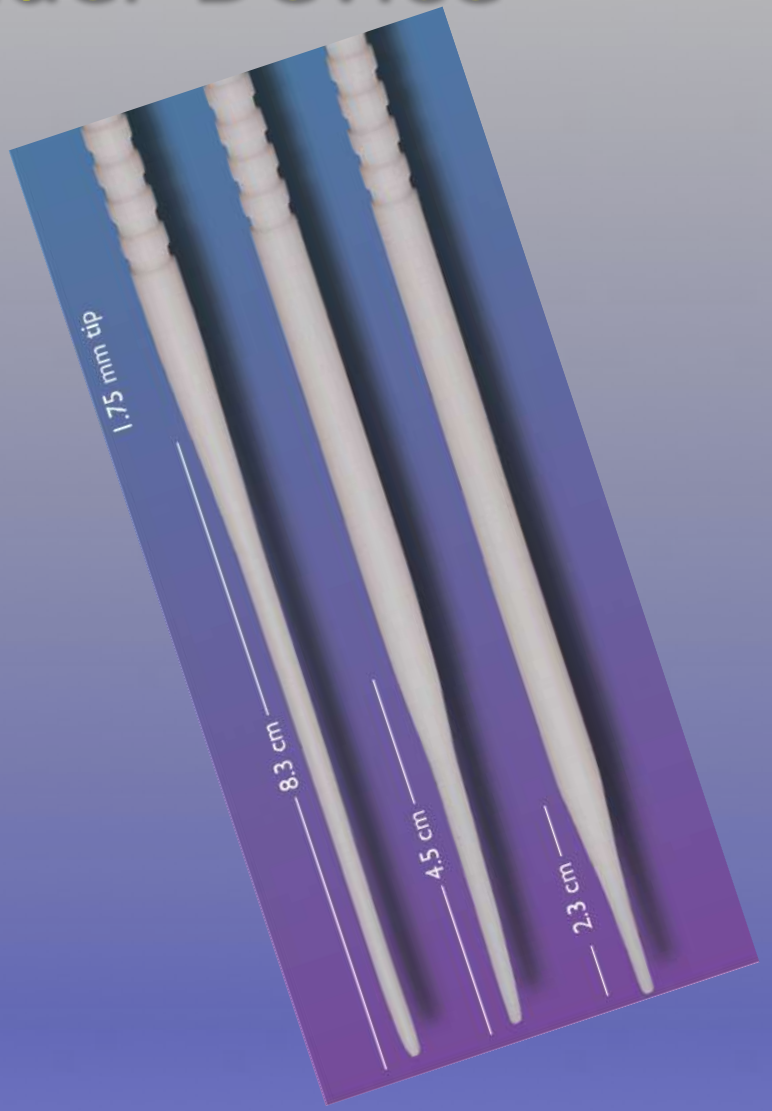
3. Gently hold the sound at the internal os and then wait --to allow the os to yield
4. Change the curvature of the sound (if metal)
5. Apply light pressure at various angles 360° and positions with the sound looking for an opening
6. Approach more anteriorly or posteriorly

Have you used ultrasound guidance?

Still Unable To Pass Through the Internal Os

7. Use os finder device
8. Use a thinner sound (endometrial sampler)
9. Dilate internal os with small metal or plastic dilator
10. Try a shorter wider speculum
11. Reposition the tenaculum onto a different place

Os Finder Device



Cervical Os Finders (Disposable Box/25)
Cervical Os Finder Set (Reusable Set of 3)

Dilators

- Dilate internal os with metal dilators
- #13 french
  - Divide by 3.16 to get mm (4.1 mm)
- Double ended
- Tapered ends ease passage through os

"Failed First Attempt"

12. If unsuccessful, return after misoprostol 200 mg per vagina 10 hours and 4 hours prior to placement

13. Place paracervical *or* intracervical block at any point

Bahamondes, M. V. (2015). *Hum Reprod,*

Passed Through with Sound …But not the Device!

1. Choke up on the handle
2. Sterile lubricant on tip
3. Leave a (small) sound in the canal and come alongside the sound with the inserter

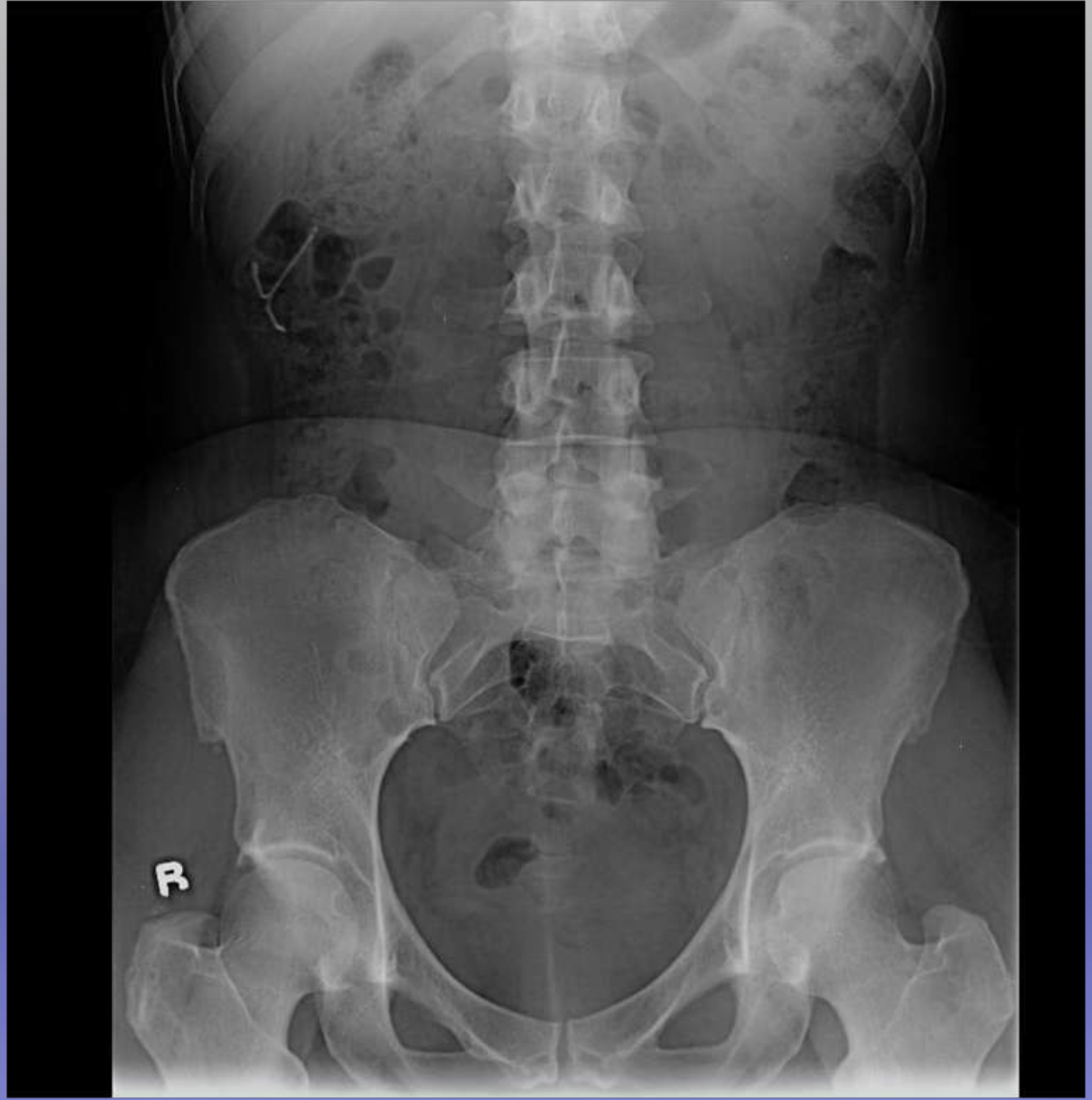
Gina G_3P_3
"My Husband Can Feel The Strings … And It Hurt Him!"

- More likely if they are cut too short <3cm or >5cm
- 3-4 cm length is ideal
- Tuck them around the posterior lip of the cervix
- Threads soften with time in most cases
- Last resort is to trim threads up above the level of the external os
  - Also indicated in cases of reproductive coercion

Management of Complications

Jennifer 39 year old G_2 P_2 "What Was That Pain?"

- 6 wk post-partum visit (NSVD)…wants copper IUD
- Lactating, no longer bleeding
- Exam: 8-9 week size uterus; firm, non-tender
- During sounding, moderate resistance at the internal os…then sounded to 14 cm.
- She complained of pain only during the initial part of the sounding procedure
- What would you do at this point?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Uterine Perforation

- More likely to occur in relation to
  - Posterior uterine position
  - Post-partum placement, esp. in lactating women
  - Skill/experience of provider
- Typical location is midline at uterine fundus…if so, perforation often is asymptomatic, benign
- Suspect if sounding is much deeper

Uterine Perforation Rates

European Active IUD Surveillance Study

- Perforation: partial (20%); complete (80%)
- Perforation: 50% diagnosed first 2 months
- Adjusted risk ratio for LNG: 1.6 (95% CI 1.0-2.7)
  - Adjusted for age, breastfeeding and pregnancy

Heinemann K, et al. *Contraception*. 2015

Uterine Perforation Rates

European Active IUD Surveillance Study

- Perforation rates by 12 months
  - LNg: 1.4/1,000
  - Copper: 1.1/1,000
- Breastfeeding (BF) significantly increased risk
  - RR (BF vs non-BF): 6.1 (9.5% CI 3.9-9.6)
  - No difference between IUD types
- No serious injury to intraperitoneal or pelvic structures

Heinemann K, et al. *Contraception*. 2015

Factors That Didn't Affect Perforation Risk

European Active IUD Surveillance Study

- Cervical dilation at time of placement
- Use of anesthesia
- Ever cesarean section
- Last delivery by cesarean section

Heinemann K, et al. *Contraception*. 2015

Management of Uterine Perforation

- If *before* insertion of IUD, stop procedure
- If *during* insertion of IUD, remove IUD
- Monitor for 30 min for excessive bleeding, pain
- Provide alternative method of contraception
- Can insert another device after next menses

Prevention of Uterine Perforation

- Move slowly and intentionally
- Avoid momentum; moving quickly increases momentum
- Once you have passed through the internal os—*STOP and pause for a second.*
- Then intentionally proceed to the fundus in a controlled fashion

Prevention of Perforation

You will feel resistance when the uterine sound touches the fundus

- This "fundal feel," or resistance should be a signal to STOP advancing the sound
- Never push beyond fundal resistance even if the flange is not yet at the external os

Prevention of Uterine Perforation

- Careful assessment of uterine position
- Exert adequate traction with the tenaculum to straighten the axis of the uterus
- Careful hand positioning when using the sound and the inserter
- Consider using a plastic sound
- Avoid excessive force during sounding and placement
- Do not use the white stabilizing rod as a plunger during placement of a copper IUD

Prevention of Uterine Perforation

- Place cervical block and dilate cervix if resistance is encountered
- Don't use inserter to sound; open IUD package only *after* sounding is completed

Betsy 17 year old G_0

- While having her LNg IUD placed, Betsy says, "Is this going to take much longer? I really need to go to the bathroom"
- What's going on here??

Betsy 17 year old G_0

- She recalls after the fact that she had a fainting spell after her HPV immunization
- She had told her PCP about this problem…heart auscultation and an ECG were normal.

Vasovagal Response, Episode Or Attack
AKA: Non-cardiogenic Syncope

- Mechanism
  - –Starts with peripheral vasodilation
  - –Bradycardia + drop in B/P
- More likely with
  - Pain with cervical manipulation
  - Previous episodes of vaso-vagal fainting

Grubb BP N Engl J Med 2005

  - Dehydration or NPO

Presyncopal Signs

- Facial pallor (distinct green hue)
- Yawning
- Pupillary dilatation
- Nervousness
- Diaphoresis
- Slurred or confused speech

Grubb BP N Engl J Med 2005

Presyncopal Symptoms

- Weakness/light-headedness
- Visual blurring/tunnel vision
- Nausea
- Feeling warm or cold
- Sudden need to go to the bathroom
- Tinnitus

Grubb BP N Engl J Med 2005

Vasovagal Prevention

- Good hydration (electrolyte/ sports drink)
- Eat before placement
- Prophylactically contract muscles if known history

Grubb BP N Engl J Med 2005

How to Abort a Vasovagal

- Isometric contractions of the extremities
- Intense gripping of the arm, hand, leg and foot muscles
- No need to bring the legs together or change position– just tense the muscles
- These contractions push blood back into the center of the body
- ….and abort the reflex

Rosa 50 yo G_3 P_3
"I Can't Feel The String"

- IUD inserted 8 years ago
- Remembers that it had a T shape, but not sure which type of IUD was inserted
- Hasn't been able to feel the string for the past 2 months, but before that checked irregularly
- String is not present at the external cervical os

Rosa 50 year old G_3P_3

- Clinical dilemmas
  - Determination of IUD location
  - Extraction of IUD without visible string

IUD Without Strings

- What type of IUD is it?
- Does she desire pregnancy?
- Is she experiencing side effects?
- Does she want another method?
- Review the benefits and risks of removal

Missing String…Possibilities

- IUD in-situ
  - String coiled in canal or endometrial cavity
  - String short, broken, or severed
- Unnoticed expulsion
- Intrauterine pregnancy

Missing String…Possibilities

- Malpositioning of the IUD, following perforation
  - Embedment into the myometrium
  - Translocation into the abdomen or pelvis
- The perforation is not the problem; the abnormal position of the IUD is!

Missing String: Expulsion

- Occurs in 2-10% IUD insertions within first year
- Risk of expulsion related to
  - Provider's skill at fundal placement
  - Age, parity, uterine configuration
  - Time since insertion (↑ within 6 mos)
  - Timing of insertion (menses, postpartum, post-abortion)

Missing String: Expulsion

- Unnoticed expulsion may present with pregnancy
- Partial expulsion may present with
  - Pelvic pain, cramps, intermenstrual bleeding
  - IUD string longer than previously

Missing String: Pregnancy With IUD

- Determine site of pregnancy (IUP or ectopic)
- If termination planned, await TAB to avoid triggering spontaneous abortion (SAB)
- If continuing IUP and strings are not visible, do not attempt removal
  - Increase surveillance for SAB, pre-term birth
  - No greater risk of birth defects, since IUD is outside of the amniotic sac

Missing String: Other Possibilities

- Translocation
  - Since copper IUD may cause more adhesions, must extract promptly via laparoscopy
  - LNG-IUS is less reactive, but most experts recommend laparoscopic removal

Missing String: Other Possibilities

- In situ placement: desires retention
  - Leave in place for remainder of IUD lifespan
  - Option: annual pelvic ultrasound *in lieu* of string check

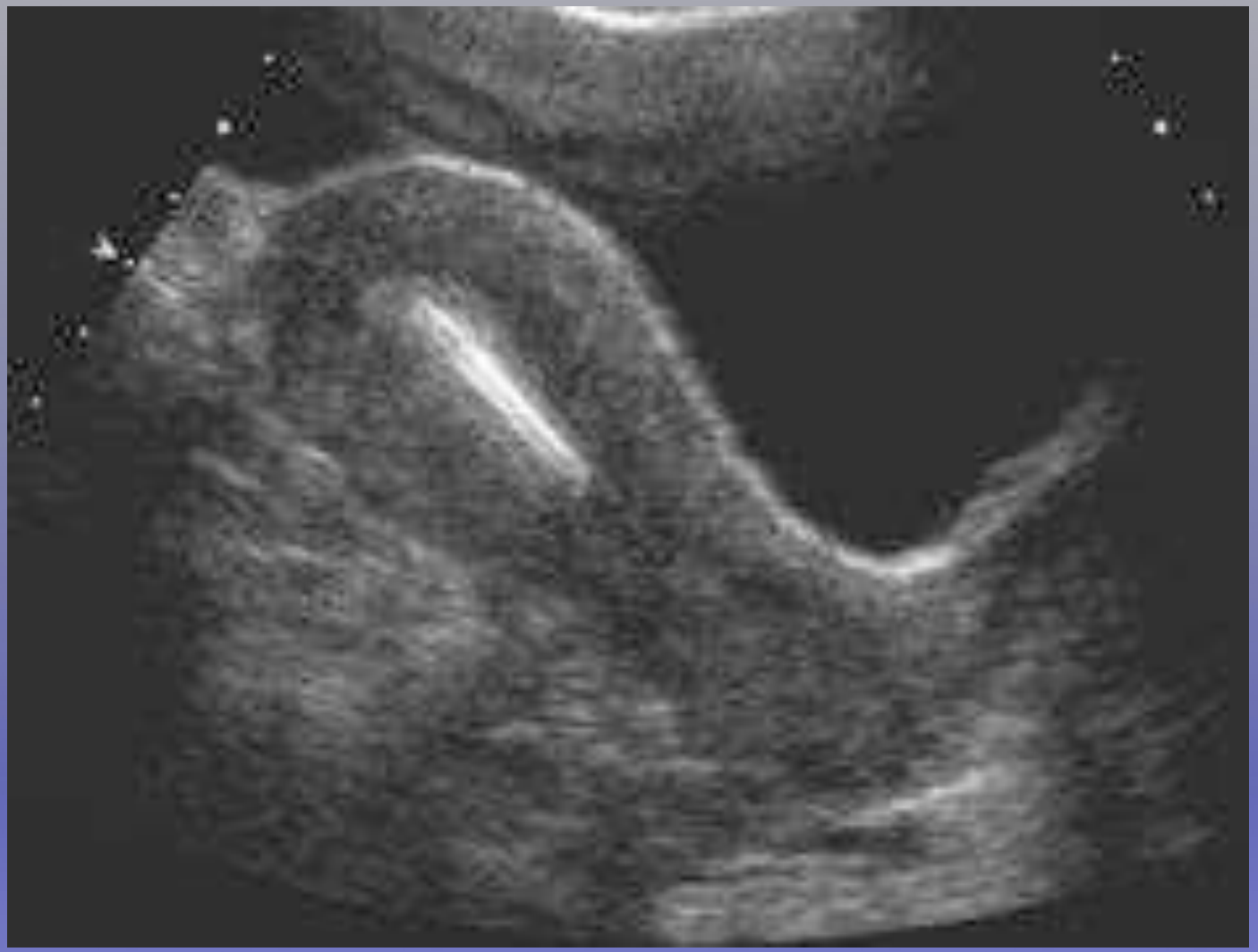
Missing String: Initial Management

- Ask Rosa whether removal or retention is desired
- Assess pregnancy status with menstrual history or UPT
  - Positive: locate and date pregnancy
  - Negative: may attempt extraction

Missing String: Initial Management

1. Sweep string from canal
2. Pregnant? → perform office UPT
   - Positive: locate and date pregnancy
   - Negative: go to #3
3. Office ultrasound, if available
   - No IUD in situ: order KUB
   - IUD in situ: go to #4
4. Retention desired?
   - Yes: may continue use
   - No: attempt extraction

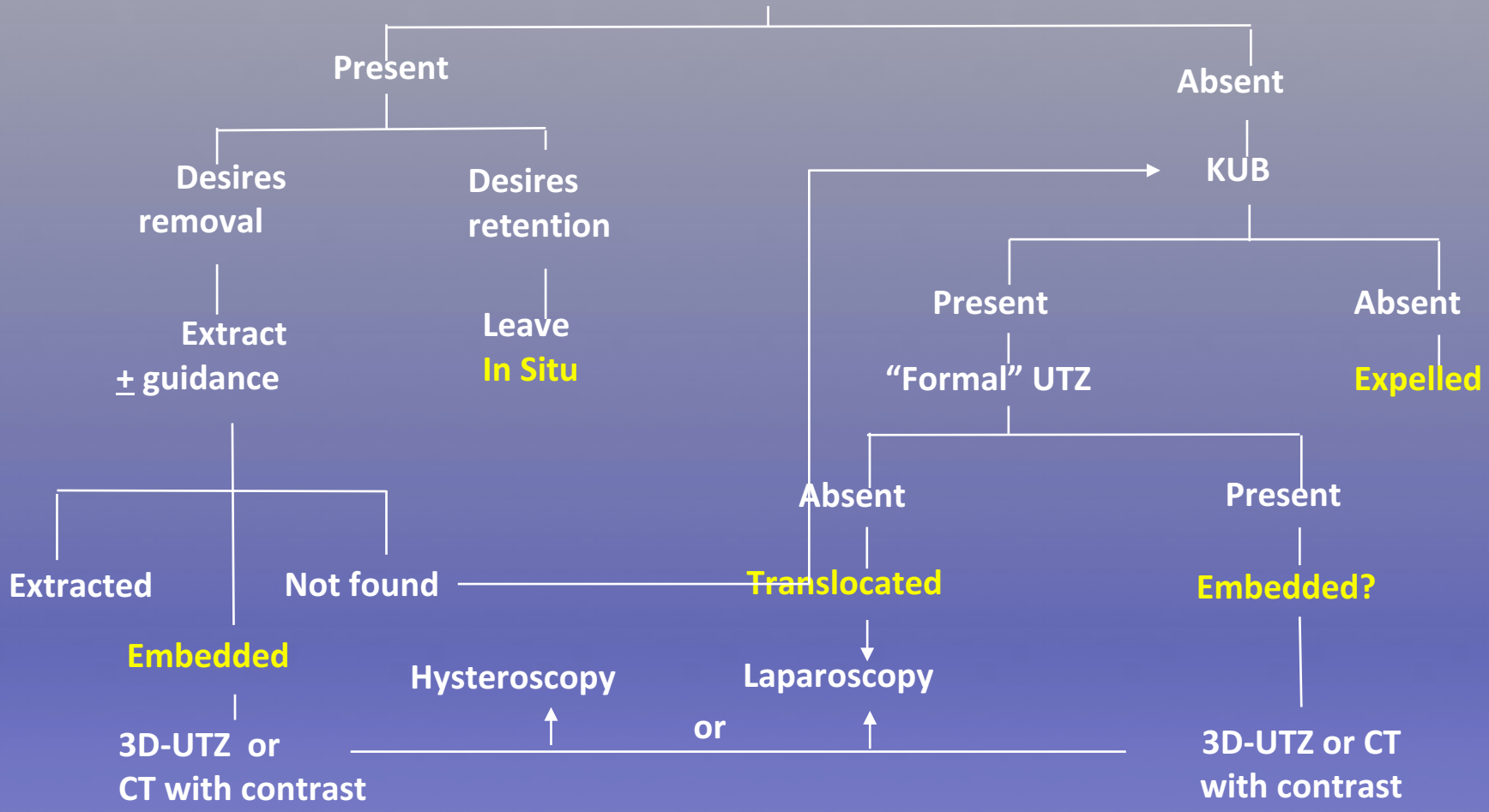
Missing String: Ultrasound Guidance



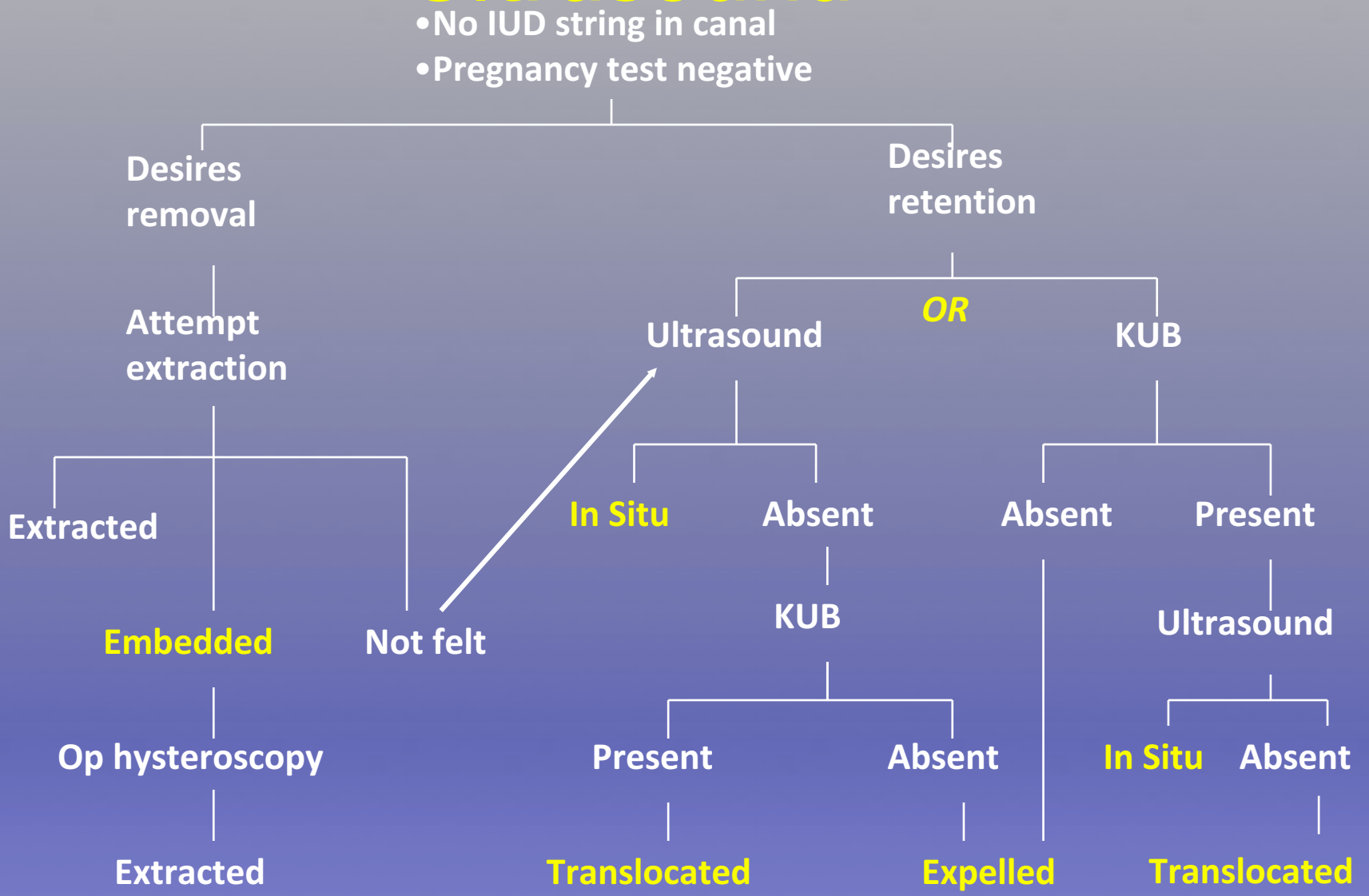
Carrie Cwiak, MD, MPH

Missing String: Office Ultrasound

- No IUD string in canal
- Pregnancy test negative
- Office ultrasound (UTZ)



Missing String: No Office Ultrasound

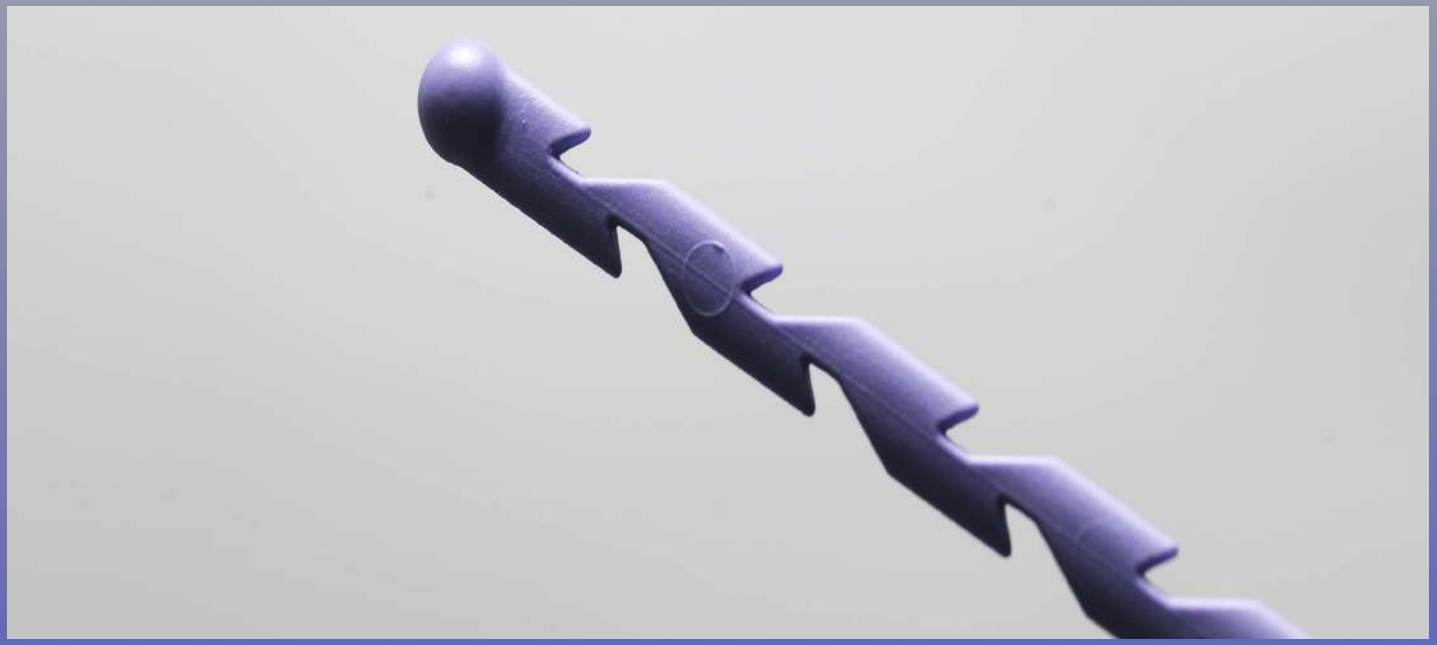


Missing String: Desires Removal

Extraction of IUD in-situ

1. Consent for uterine instrumentation procedure
2. Bimanual exam
3. Probe for strings in cervical canal
4. Apply tenaculum
5. Administer cervical block
6. Choose extraction device
   - Emmett Thread Retriever
   - Patterson alligator forceps
   - Ring IUD: crochet hook or 3-5 mm suction curette

Emmett Thread Retriever



Thread Retriever

Alligator forceps

Fulcrum 1 cm from the tip of the device

Opened and closed completely within the uterine cavity

No cervical dilation necessary

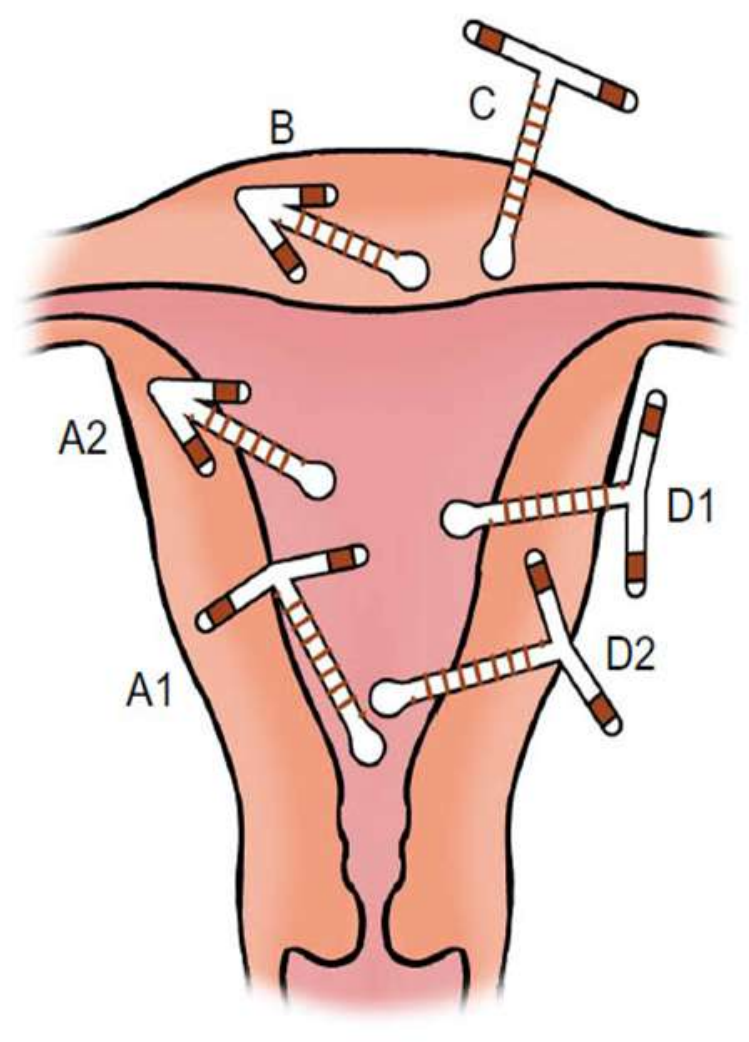
Prabhakaran S, Chuang A, *Contraception* 2011.

Missing String: Desires Removal

Extraction of IUD in-situ

7. Intrauterine exploration for a T-shaped IUD
   - Real-time ultrasound guidance may help, if available
   - Gently open/ close/quarter turn forceps at progressive depths until “purchase” of stem or arm
8. Maneuver hook along anterior, then posterior, uterine wall from fundus to canal
9. If embedment suspected, consider evaluation with 3-D ultrasound or pelvic CT with contrast
   - Extract via operative hysteroscopy or laparoscopy

Why Do CT or 3-D Ultrasound?



Answer:
To decide whether to start the extraction with laparoscopy or hysteroscopy!

Missing String: Desires Removal

Additional measures, as indicated

- Pain management
  - Cervical block + oral NSAIDs for pain
  - Conscious sedation
- Cervical dilation
  - Osmotic dilator
  - Rigid dilators
  - Misoprostol *may* facilitate IUD extraction

Sharonda G_3 P_2

- Had a Cu IUD placed 6 months ago
- LMP 6 weeks ago
- Breast tenderness, nausea
- No pain or bleeding
- Positive pregnancy test
- Wants to continue the pregnancy

Pregnancy with IUD In Situ

- Determine if IUP or ectopic
- If intrauterine pregnancy confirmed
  - Counsel Sharonda on risks
  - Removal decreases risk of spontaneous abortion, premature delivery
  - If Sharonda consents:
    - Remove IUD if strings visible
    - If she were planning termination: could remove IUD or await procedure

If Strings Not Visible
Retention of IUD During Pregnancy

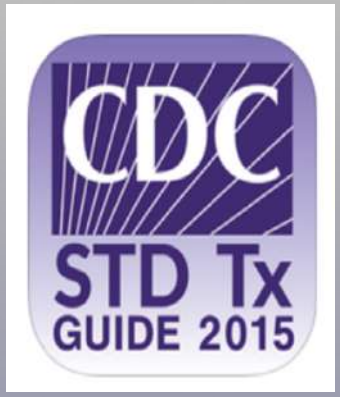
- Increase surveillance for SAB, pre-term birth
- No greater risk of birth defects (extra-amniotic)

Donna 22 year old G_0

Pelvic Infection with IUD in Place

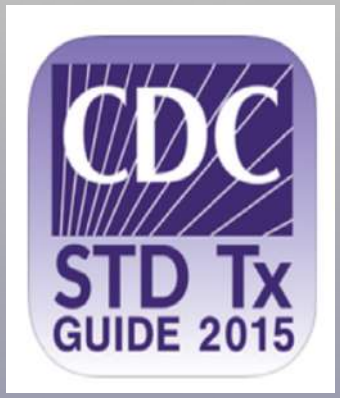
- Skyla® placement done 6 months ago
- Complains of midline pelvic pain for the past 4 days
- Discloses unprotected sex with new partner
- Exam shows
  - Afebrile; normal vital signs
  - 3/4 bilateral lower quadrant tenderness
  - 3/4 uterine corpus tenderness + bilateral adnexal tenderness
- Wants to keep IUD

PID in an IUD User



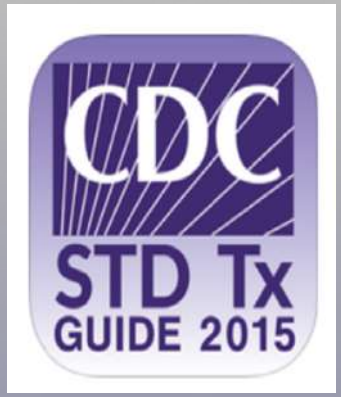
- Treat PID according to the CDC STD Treatment Guidelines
- Provide management for STDs
- Counsel about condom use
- The IUD does not need to be removed at time of treatment

PID in an IUD User



- Reassess in 48–72 hours
  - If no improvement, continue antibiotics and consider removal of the IUD
- If removal requested, do so after antibiotics started to avoid the risk of bacterial spread
- If the IUD is removed, consider ECPs if appropriate

STD Treatment Guidelines (p82)



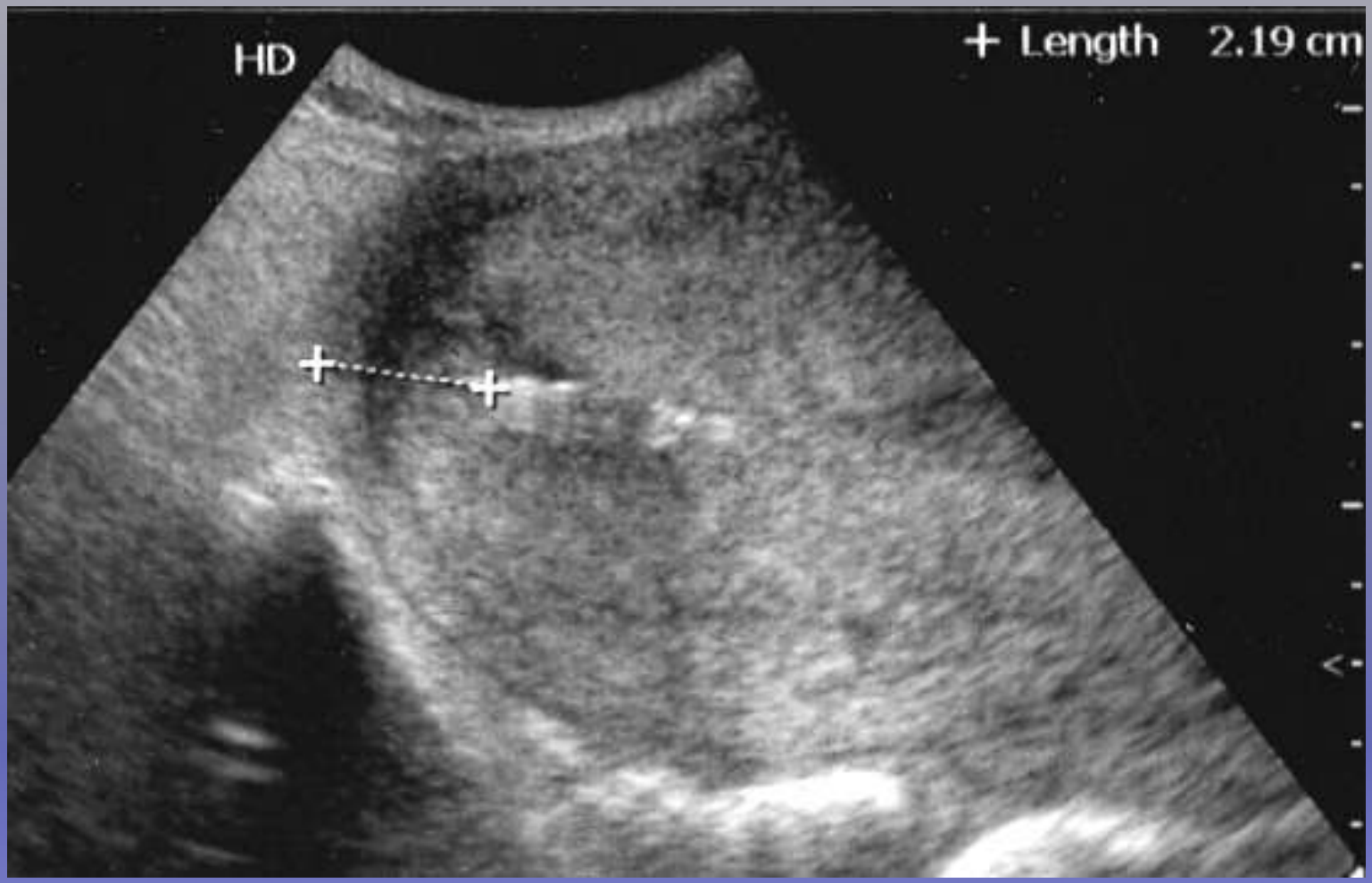
Treatment outcomes did not generally differ between women with PID who retained the IUD and those who had the IUD removed

Actinomyces-Like Organisms (ALO)

- *Actinomyces israelii* has characteristics of both bacteria and fungus; part of GI flora
- May asymptomatically colonize the frame of the IUD, which in itself is not dangerous
- Very small percentage of women with IUD + actinomyces will develop *pelvic actinomycosis*
  - Presentation is similar to severe PID
- Women with ALO on Pap smear
  - Should be examined to exclude PID
  - If none, don't treat actinomyces or remove IUD

Postpartum IUD Placement

Post-placental Mirena Insertion



Postpartum IUC Placement

- Pros
  - One procedure (vs delivery and delayed placement)
  - Protection if patient doesn't return for visit
  - Cost saving to health system, including adolescents
- Cons
  - High rate of expulsion (15-20%) vs. delayed placement
  - Delivery room challenges, until system established
  - Pushback from hospital administration if not line-item reimbursement from payer

How Is Postpartum IUD Insertion Done?

- IUD placement after vaginal delivery
  - Insert IUD within 15 minutes of placental delivery
  - Use sponge forceps on cervical lip; 2nd forceps to place IUD at uterine fundus
  - Cut string flush with external cervical os
- IUD placement at caesarean section
  - After delivery of newborn and placental removal…
  - Manually place IUD at fundus; tuck strings thru cervix
  - Repair uterus and complete c-section
  - Trim strings at postpartum visit

Excellent Time for IUD Insertion- Post Abortion

- Of 1.3 million abortions/yr in US, half are repeat
- 40% of women scheduled for delayed IUC insertion did not return for the procedure
- 83% ovulate with the first cycle after the procedure
- Immediate post-abortal IUC insertion is a safe, effective, practical, and underutilized intervention
- Can reduce repeat unintended pregnancy

Why Do a Post-Abortion IUC Placement?

- Advantages
  - One procedure rather than two
  - Less or no pain with insertion, since cervix is dilated
  - Immediate protection; avoid pregnancy risk if 2nd visit is delayed or doesn't occur
- Disadvantages
  - Slightly higher expulsion rate
    - 2nd tri TAB: 3-10%, 1st trimester TAB: 5-6%
    - No TAB: 1-4%
  - Is the decision to use an IUC biased while pregnant?

Bednarek P, et al N Engl J Med 2011; 364:2208-2217
Cremer KM, et al Contraception 2011; 83:522-527

Post Abortion IUD Insertion

- No difference in complications for immediate versus delayed insertion of an IUC after abortion
- There were no differences in safety or expulsions after insertion of an LNG-IUC compared to Cu-IUC
- Expulsion greater when an IUC was inserted following a 2nd trimester vs. a 1st trimester abortion
- US Medical Eligibility Criteria 2016
  - First trimester abortion: US MEC-1

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Outline

1. Efficient practices for same-day placement of IUDs
2. IUD counseling tips, including optimal language during client counseling
3. Nuances of informed consent…terms to explain to possibility of…
4. Difficult placements
    - Kristin: Negotiating the challenging internal os
    - Sarah: Obese patients
    - Rachel: Patients with fibroids

Outline

5. Outpatient procedure pain relief principles and application (Mary: an anxious patient)
   - Verbicaine
   - Distraction
   - Slow technique
   - Oral analgesia and sedation
   - Tenaculum site local anesthetic
   - Paracervical and intracervical block

Outline

6. Responding to IUD complaints and side effects
   - Partner feels the string
   - Managing bleeding irregularities
7. Management of complications
   - Missing strings
   - Perforation, translocation, and embedment
   - Expulsion
   - Pregnancy
   - Infection
8. Techniques and controversies postpartum IUD placement
9. Encounter coding for IUD services
10. Advanced-level case studies

Title Slide:
Same Day Placement

Barriers to Same Day Placement

- Provider(s) not trained or confident of abilities
- Provider misconceptions
- Office practice logistics
- Payment misconceptions

Provider Misconceptions

- "GC and CT screening test results are necessary"
  - Routine screening not indicated
  - If indicated, can be done at time of placement
- "IUDs can be placed only with menses"
  - Anytime if reasonably certain that not pregnant
- "Adolescents or women with multiple sexual partners are not candidates for IUD"

Office Practice Logistics

- "Placement adds too much time to a scheduled visit"
  - Adds no more than 5-10 minutes if each exam room is well stocked and the staff is prepared
- "Placement only at scheduled placement visits"
  - Any clinic visit is a potential placement visit
    - Well woman visit
    - Post-partum visits
    - Pregnancy test visits

Payment Barriers

- "IUD can be placed only after delivery from a PBM"
  - Keep extra insertion kits in the office
  - Replenish with the kit delivered from PBM
- "Method counseling and placement cannot be billed on the same date of service"
  - It definitely can be done...see ACOG and UCSF "Beyond the Pill" billing guides

Title Slide
IUD Counseling Tips

Choosing Which IUD

Brand Name	Skyla®	Kyleena®	Mirena®	Liletta®
LNG content (mg in reservoir)	13.5	19.5	52	52
Release rate (mcg/24 hrs) -- at end of life	14 5	17.5 7.4	20 +/- 10	19.5 17, 14.8, 12.9, 11.3, 9.8
Max duration, years	3	5	5 (7)	3 (5-7)
T-frame, mm	28 x 30	28 x 30	32 x 32	32 x 32
Insertion tube diameter	3.80	3.80	4.40	4.80
String color	Brown	Blue	Brown	Blue
Silver ring	Yes	Yes	No	No

Particular Characteristics Of IUDs

- Do you have a sense of what is important to you about your method?
- Do you have a sense of what you are looking for in a contraceptive method?

Elicit Her Attitudes About

- Effectiveness
- Hormones
- Menstrual cycle and bleeding profile
- Length of use
- Control over removal
- Object in her body
- Return to fertility
- Non-contraceptive benefits
- Side effects

Re-phrasing

- “So I hear you saying …(you really like the idea of using a method without hormones) do I have that right?”

- “It sounds like….(it’s super important to you have a method that you can rely on) is that what you mean?”

Alternates

- “Many of my patients say that they worry about weight gain with birth control is that what you mean?”

- “Wow, so you feel pretty strong about avoiding the side effects you had from the pill and the shot is that accurate?”

Limit the Amount of Information

- Humans do not integrate large amounts of information
- More information = less retention
- Focus on her specific needs and knowledge gaps
- Give information in response to her questions or in a dialogue

Information Sandwich

One piece of information with a question on each side:

- How would that be for you?
- Knowing that how would it be for you…?
- Has it ever happened before?
- How did you manage it?
- Do you have a sense of how you would manage it?

Language: Don’t Say LARC

Use the words “long acting” ONLY if that’s what she said she is looking for

- Top tier
- One of the most effective methods
- Cadillac, Mercedes, BMW…
- Highly effective method

Language for IUDs

"This IUD is good for *up to* _____years but if you want to get pregnant before then or you would like it out for any reason, come in, we will take it out for you and your ability to get pregnant will return *to whatever is normal for you immediately*."

12, 10, 7, 6, 5, 3

Teach Back

Ask patient to restate important messages in her or his own words

Take it on yourself:

"We went over a ton of information! Just so I'm sure that I've been clear, can you tell me what you will do to decrease your bleeding with your period once you have the copper IUD?"

Responding to "Unfounded" Concerns

"That's too bad your friend had that experience. I haven't heard of that before, and I can tell you it definitely doesn't happen frequently."

Try NOT to Disagree

- Whenever possible, find something in what she is saying to agree with and then add your scientific or medical information.

- “Yes! …. and…” Instead of “No” or “But”

Find the "Yes"

Rather than…

- "No, that's just an example of good old "Dr. Google" that's not true at all!"

Try…

- "It's great you took the initiative to look this up on your own! I can see you're really interested in taking care of yourself" "I have a great resource for you that I think you will love…" (Bedsider.org)

Amenorrhea with LNG IUD

Don't…

- Assume you know why she objects to amenorrhea
- Ask her "why"

Do…

- Ask what about not getting her period is concerning to her
- Let her know many women feel that way

Use an information sandwich

Question—Information—Question

Or: Question—Rephrase—Information—Question

Meena 29 G1P1
"What is it about not getting your period that is concerning to you?"

"I would always worry that I might be pregnant"

"I can see that it's very important to you not to get pregnant until you are ready"

"Many of my patients like to get their period every month because they feel like it lets them know they aren't pregnant"

Meena 29 G1P1

“Interestingly many women still bleed in the beginning of a pregnancy...”

“Pregnancy tests at the 99 cent store are plentiful and can be very reassuring!”

Natural Frequencies

"If a woman switches from the pill to an IUD her chance of unintended pregnancy is reduced from 90 in 1000 to <2 in 1000"

"If 100 women have unprotected sex for a year, 85 of them will get pregnant as opposed to none or maybe one out of 100 using a hormonal IUD"

Not:

"<1 % failure"

Kristal 22 G2P1
"My mom said it's not healthy not to get my period"

"Your mother is completely right!.... when you are not on contraceptive hormones it is important to get you period every month, it's great that you know that"

"I'm so glad you know that when you are not on contraceptive hormones and you miss your period you need to come in so we can see what's up!"

Kristal 22 G2P1
"My mom said it's not healthy not to get my period"

"I wish all of my patients knew that if they miss their period and they aren't on contraceptive hormones it could mean something is wrong!"

... "Interestingly, if a woman *is* using contraceptive hormones it keeps her uterus very healthy and thin. It actually prevents cancer of the uterus" (Show a picture)

Ask a question

“Knowing that, how would it be for you not getting periods?”

Title Slide
Nuances of Informed Consent

Informed Consent

- Expulsion
- Infection
- Perforation
- Method failure (pregnancy)

Difficult or Challenging Placements

Kristin: Negotiating the challenging internal os
Sarah: Obese patients
Rachael: Patients with fibroids

Kristin 23 year old G_0

- On DMPA for the last 3 years
- Prior LEEP age 25

- Audience writes tips

Tenaculum

1. Change the amount of traction

2. Apply traction in different direction

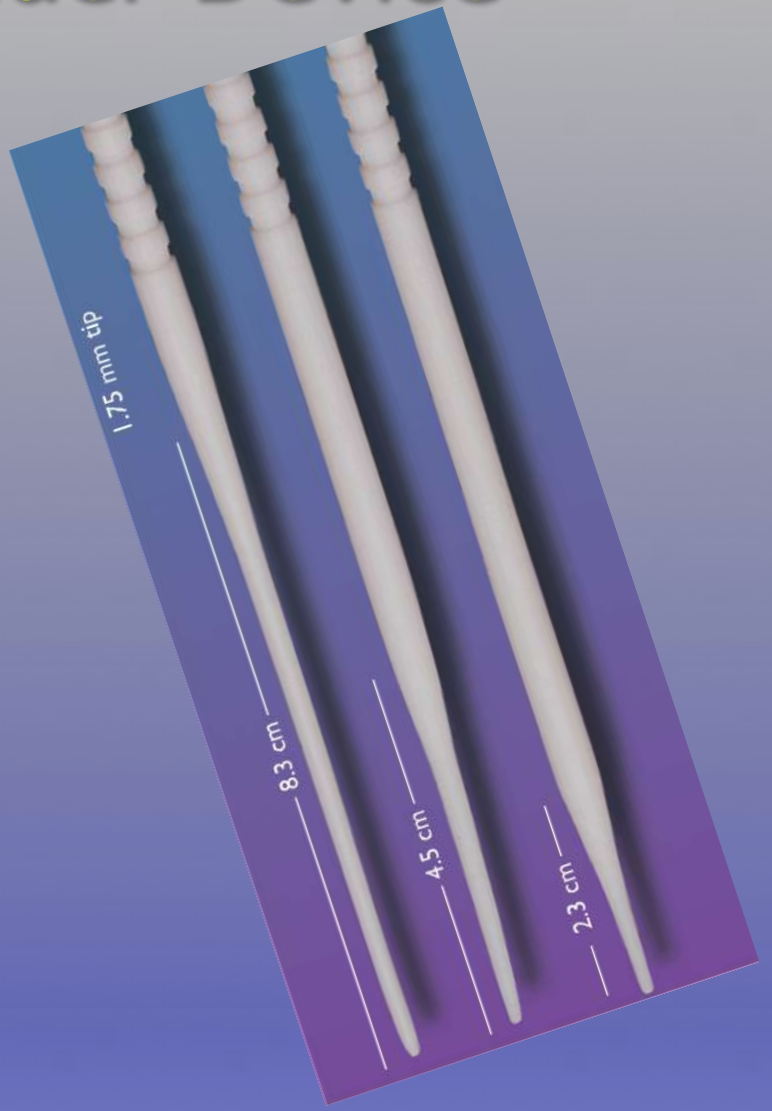
Uterine Sound

3. Gently hold the sound at the internal os and then wait --to allow the os to yield
4. Change the curvature of the sound (if metal)
5. Apply light pressure at various angles 360° and positions with the sound looking for an opening
6. Approach more anteriorly or posteriorly

Still Unable To Pass Through the Internal Os

7. Use os finder device
8. Use a thinner sound (endometrial sampler)
9. Dilate internal os with small metal or plastic dilator
10. Try a shorter wider speculum
11. Reposition the tenaculum onto a different place

Os Finder Device



Cervical Os Finders (Disposable Box/25)
Cervical Os Finder Set (Reusable Set of 3)

Dilators

- Dilate internal os with metal dilators
- #13 french
  - Divide by 3.16 to get mm (4.1 mm)
- Double ended
- Tapered ends ease passage through os

"Failed First Attempt"

12. If unsuccessful, return after misoprostol 200 mg per vagina 10 hours and 4 hours prior to placement

13. Place paracervical *or* intracervical block at any point

Bahamondes, M. V. (2015). *Hum Reprod,*

Sarah 30 year old G_3P_3 BMI 41

- Sarah is in the office for a Cu IUD placement
- Attempts to place the tenaculum are unsuccessful as the cervix keeps slipping out of view

The Elusive Cervix

- Significant uterine flexion causes cervix to be anterior or posterior
- Close partially; retract slightly; redirect
- Extreme retroversion of uterus can cause cervix to be lodged behind symphysis pubis
- Exert more pressure on posterior fornix to manipulate it into view

Bates, et. al. J Gen Intern Med 2011;26(6):651–7

Obesity: Bimanual Exam

- It may be difficult or impossible to palpate the uterus or ovaries
- Place the abdominal hand UNDER the panniculus to decrease amount of adipose tissue between the hand and the uterus
- Pelvic sonogram indicated if sounding difficult

Obesity: Have Appropriate Instruments in the Room

- Specula of varying sizes
- Ensure adequate lighting
- Tongue blades or retractors or ring forceps
  - Use closed ring forceps or tongue blade to gently push vaginal walls to the side to improve visibility

Obesity: The Right Speculum

- Too narrow--will not allow for good visualization
- Increase *width rather than length*
  - Avoid a long speculum
  - It can firmly splint the cervix in place
  - Does not allow you adequate cervical mobility to straighten the uterine flexion when using a tenaculum

Open the speculum blades at the base as well as the tip

Optimize Position

- Position Sarah as far down on the exam table as possible to allow maneuvering of the speculum once in place

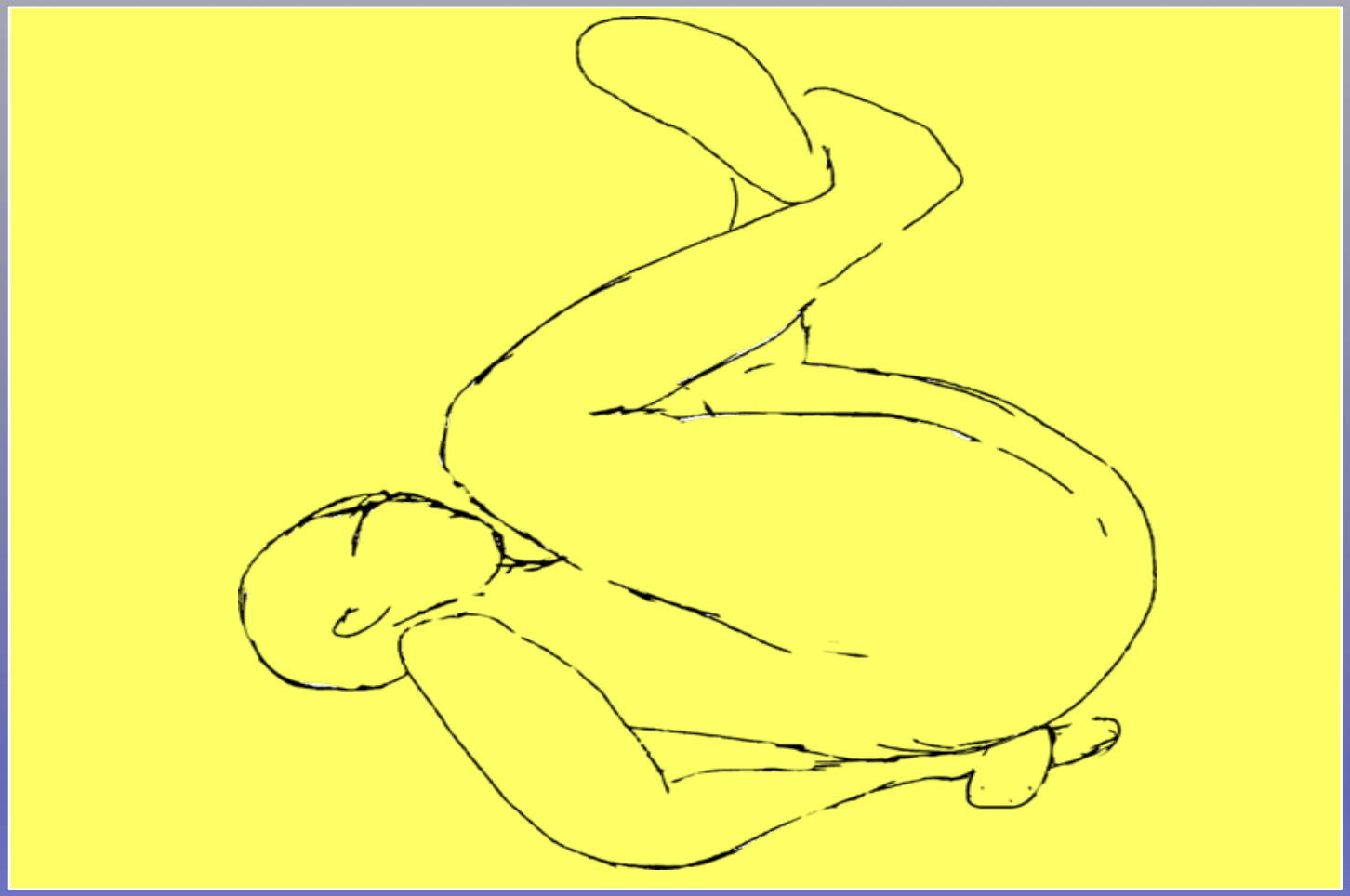
- Hips over the edge of the exam table drops her pelvis and cervix forward and makes visualization easier

Optimize Position

Raise her buttocks…

- Have her place her hands in a fist under her own buttocks
- Lower the head of the table
- Place a lift under her buttocks

“Cannon Ball” Or “Knees To Chest”



She pulls her knees up and back

Rachel: 35 year old G_0 P_0 "I Have Fibroids"

- Periods have been heavier and longer for 2 years
- Bimanual exam: Irregular 12 week size uterus
- Choses a LNg-IUS for contraception and bleeding control

- Clinical dilemmas…
  - –LNg-IUS control of fibroid-related

LNG-IUS vs Oral MPA for Heavy Menstrual Bleeding

- Randomized parallel-group trial comparing Mirena (n=79) to MPA (n=81), over 6 cycles
- Exclusions: organic or systemic conditions causing heavy bleeding (except small fibroids, not > 5 mL)

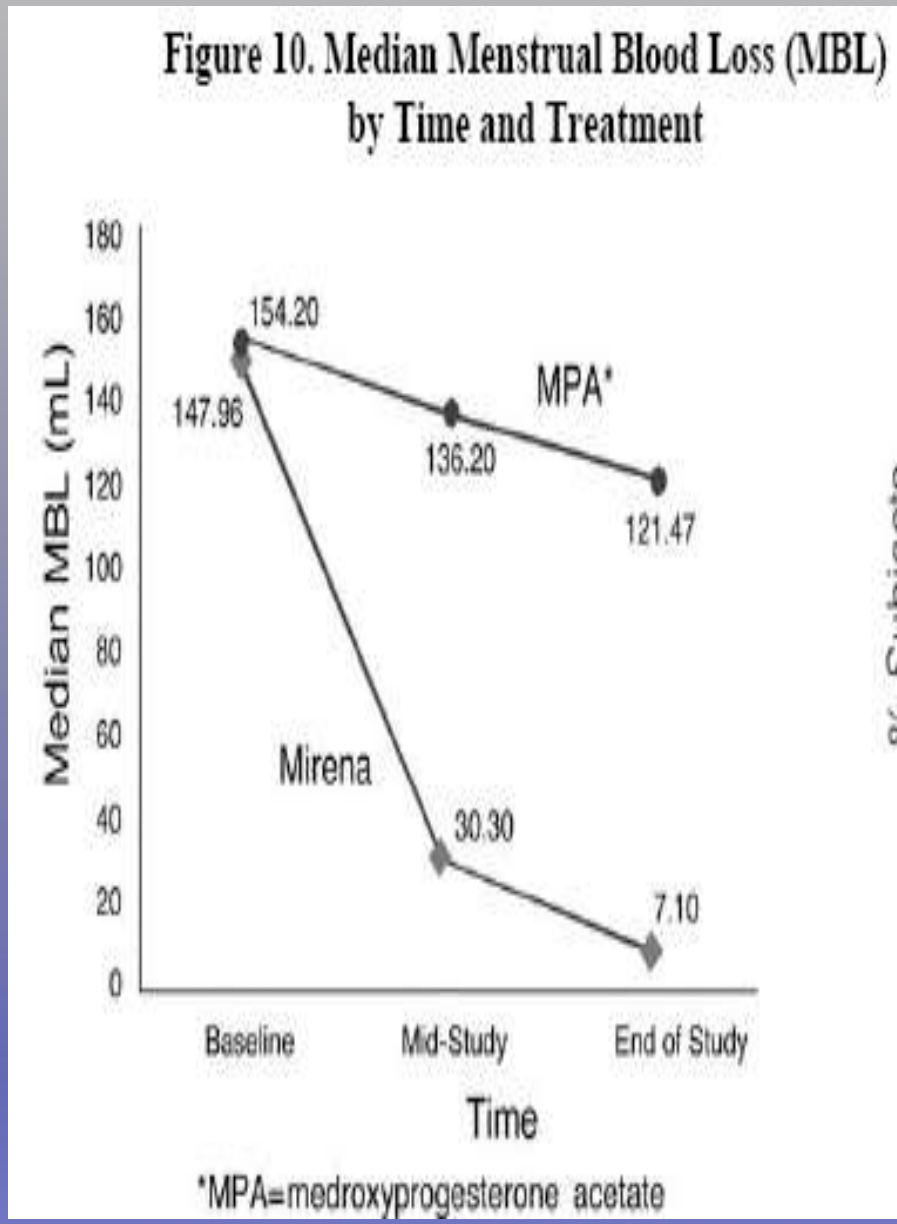
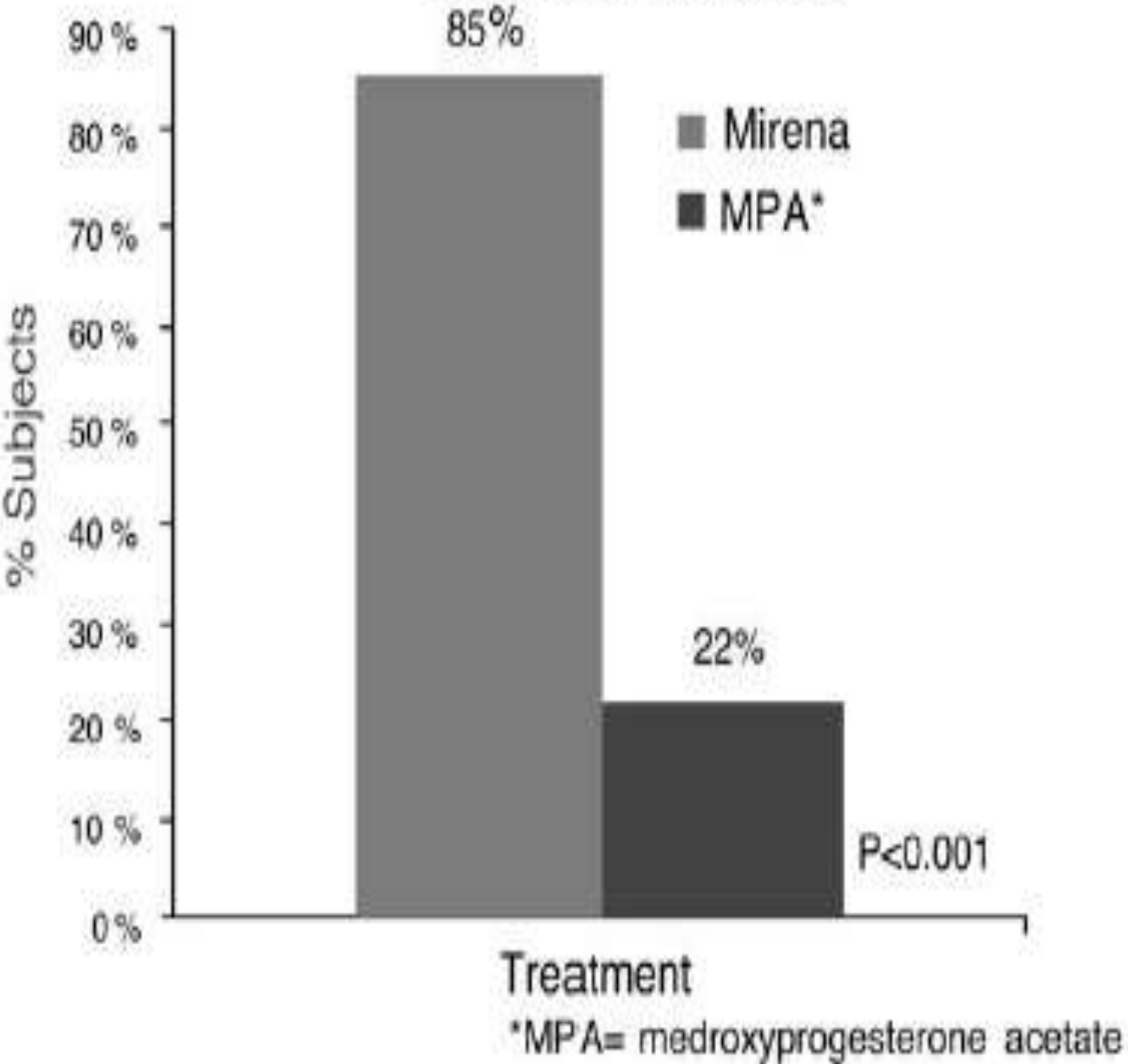
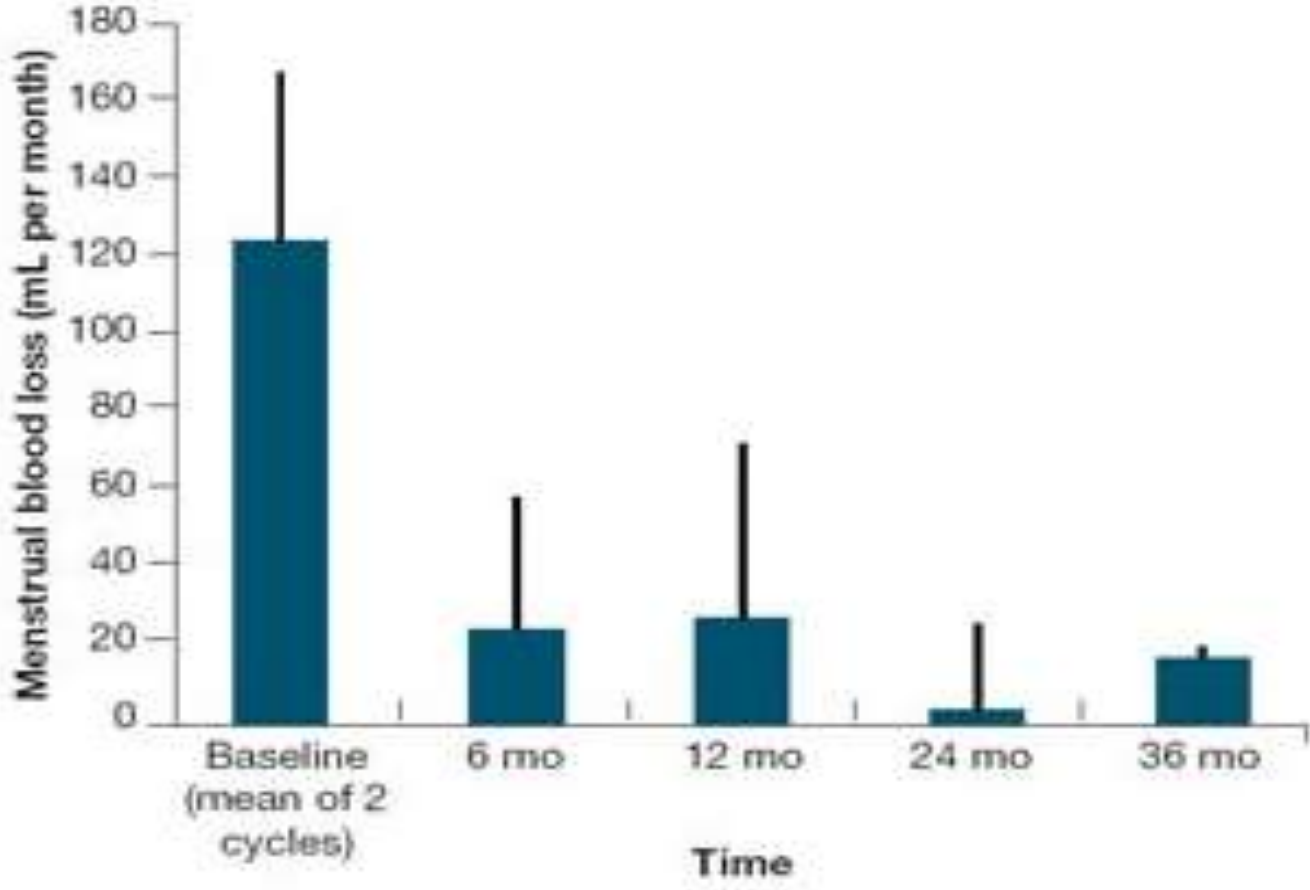


Figure 11. Proportion of Subjects with Successful Treatment



*MPA= medroxyprogesterone acetate

Menstrual Blood Loss Before and After Placement of the LNg-IUS



*Mean with standard deviation.

Xiao B, et al. Fertil Steril. 2003;79:963-969.

Comparison of medical therapies for heavy menstrual bleeding

	NSAIDs	OCs	DMPA	LNG-IUS
Dosing	Variable	Daily	3 months	5 years
Effects on blood loss	Reduction	Reduction	Reduction	Reduction
Side effects	GI	Hormonally related	Hormonally related	Occasional hormonal
Contraceptive effectiveness	None	Middle tier	Middle tier	Top tier
Typical-use 1-yr pregnancy rate	Unchanged	8%	5%	0.1%

DMPA, depot medroxyprogesterone acetate; GI, gastrointestinal; LNG-IUS, levonorgestrel-releasing intrauterine system; NSAIDs, nonsteroidal anti-inflammatory drugs; OCs, oral contraceptives.

Grimes DA. Review of Management Strategies for Heavy Menstrual Bleeding: Summary of the Best Evidence. OBG Management 10/2009

Tranexamic Acid (Lysteda) for HMB

- FDA indication: treatment of cyclic heavy menstrual bleeding
- Mechanism of action is antifibrinolytic
- Use: 1,300 mg (two 650 mg tablets) TID for up to 5 days
- Contraindications
  - Active thromboembolic disease or a history or intrinsic risk of DVT, incl. retinal vein or artery occlusion
- Cautions
  - Concomitant therapy with CHC may further increase the risk of blood clots, stroke, or MI

LNG-IUS and Fibroids

- Small studies with mixed results
  - Mercorio (2003): 75% persistent menorrhagia
  - Starczewski (2000): 92% reduced bleeding
- Recommendations
  - Off-label use; may violate precaution regarding cavity depth and distortion of uterine

IUD Insertion Tips: Women with Fibroids

- Determine fibroid location by ultrasound
  - Fundal fibroids (intramural, sub-serous) that do not distort uterine cavity do not preclude IUC use
  - Large sub-mucous fibroids, especially in lower uterine segment, contraindicate IUC use
  - Evaluate for other pathology, e.g., polyp

Mary 18 Year Old G_0 P_0 "I Am So Afraid to Have This Done!"

- Will this hurt?
- Placeholder for image

Outpatient Procedure Pain Relief Principles And Application

- Verbicaine
- Slow technique
- Oral sedation
- Tenaculum site local anesthetic
- Controversies
  - Pre-insertion NSAIDs
  - Pre-insertion misoprostol
- Paracervical and intracervical block

Verbicaine

- Keep her talking!
- Calm, soothing vocal tone
- Slow, easy pace

- Utilize whatever works for the patient
  - Breathing techniques
  - Mindful mediation
  - Guided imagery

Distraction

Oral Sedation

Mike- legally informed consent after sedation?? I would not include these two slides

- Anxiolytic
- Narcotic
- Develop a protocol for your office or clinic
- Need to have a driver or escort

Carrie Cwiak, MD, MPH

Oral Sedation

Mike- legally informed consent after sedation?? I would not include these two slides

- Alprazolam 0.5 – 1 mg OR
- Diazepam 5 - 10 mg PLUS
- Acetominophen 300 mg/codeine 30 mg OR
- Acetominophen 300 mg/hydrocodone 5 mg
- Give your client a prescription to fill and take 30 minutes before the procedure

Carrie Cwiak, MD, MPH

Non-Steroidal Anti-inflammatory Drugs

- May have some benefit for insertional pain
- Helps with post insertional cramping
- Ibuprofen 800 mg or Naproxen Sodium 550 mg

Placeholder for Cochrane Review- I Mike: I would put the citation in but not have a detailed discussion here (I put the PDF in the CT 2017 IUD folder

Tenaculum: Purpose

- Stabilize the cervix to allow passage of sound and IUD through the os
- Straighten any irregularities in the cervical canal
- Straighten uterine curvatures or flexion

Tenaculum Pain Prevention

- Only click to first or second ratchet
- Close the tenaculum very, very slowly
- Close the ratchet *silently*
- Take a bite no larger than you need

Tenaculum Pain Prevention

- 1cc Local anesthetic to tenaculum site
- Have patient cough (…hold onto the speculum)
- Don’t move the tenaculum inadvertently
- During sounding and IUC placement, don’t hook your fingers through the rings

Uterine Sound Purpose

- Insure that you can pass through the internal os
- Measurement adequate
- Informs the direction and pathway through the os up to the fundus

Uterine Sound: Which One?

- Metal sound
- Plastic sound
- Endometrial sampler
- Two sided dilator

Uterine Sound Pain Reduction

- Touch the fundus once
  - Repeated tapping is unnecessarily uncomfortable for the patient
- Move slowly and intentionally
  - Moving too quickly increases discomfort

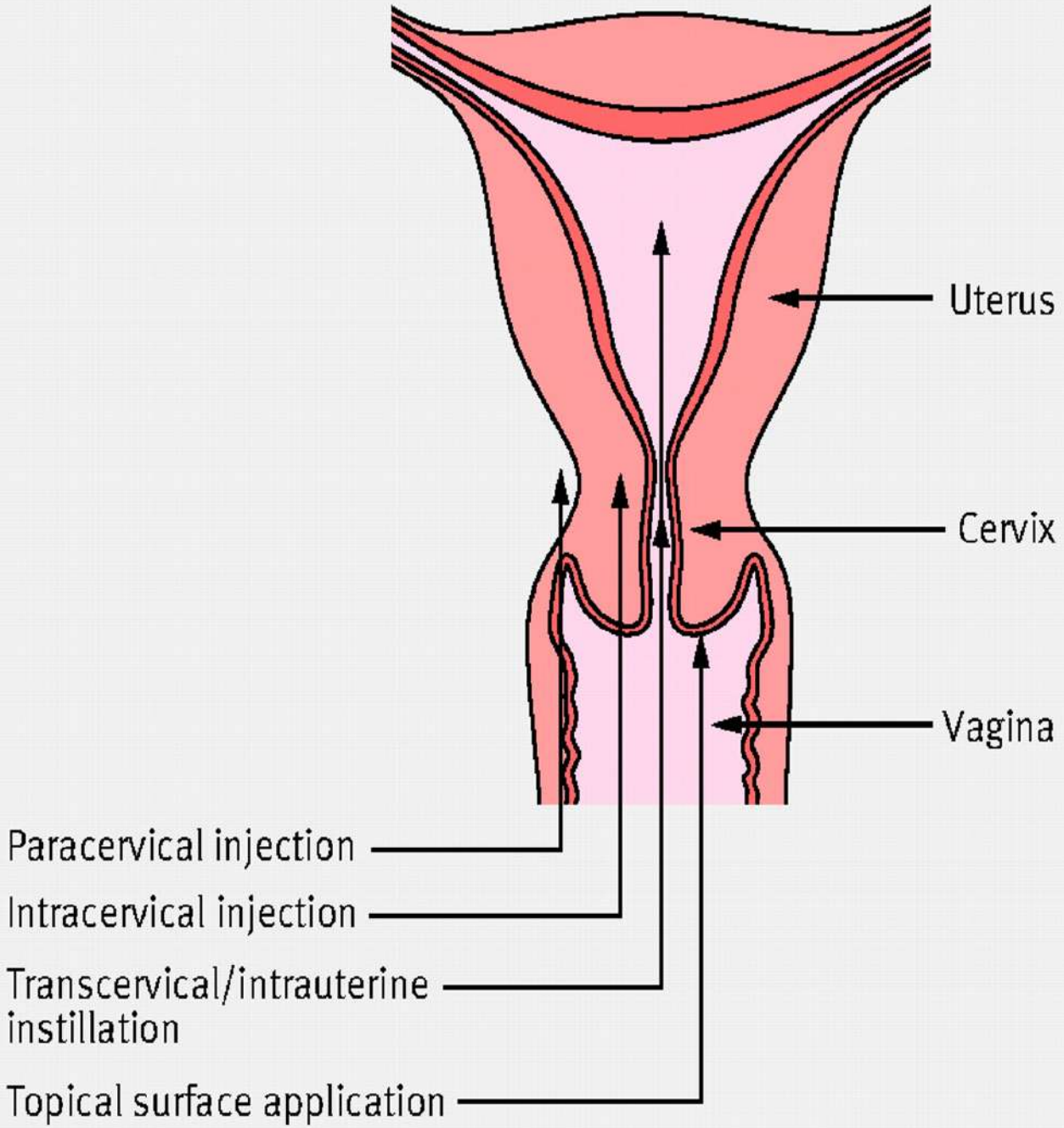
Uterine Sound

- If metal; bend sound to mimic uterine flexion
- Hold it like a pencil or dart
- Use *Wrist* action
- Brace fingertips on speculum to achieve control of force while advancing the sound

Uterine Sound: *S-l-o-w* Progression

- Through the internal os
- *Pause once you have passed through the internal os*
- Slow intentional progression to the fundus

Cervical Anesthesia



20 ml of 1% lidocaine (NO epinephrine)

Carrie Cwiak, MD, MPH

Paracervical Block

- Start with ½-1 cc. at tenaculum site
- Disguise pain of needle insertion with cough
- WAIT 1-2 minutes after placing block
- Use 10 cc. 1% lidocaine (without epinephrine)
- Inject at 4 & 8 or 4 & 5 then 7 & 8
- Submucosal injection 5mm-1cm

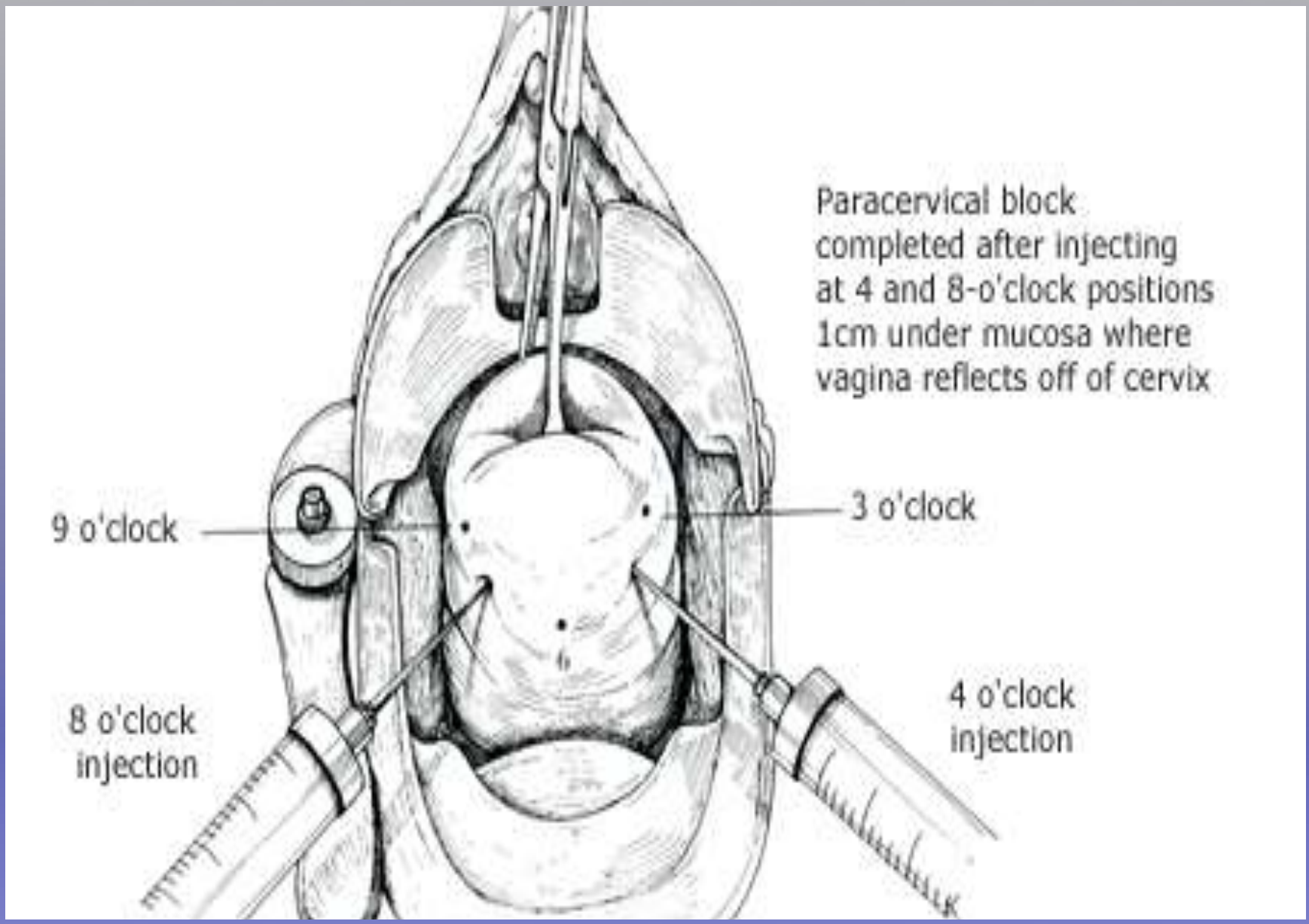
Bleeding from Tenaculum Site

- Rarely *if ever* an issue
- Seeing blood from the tenaculum site can feel scary but is not a reason for concern

To stop the bleeding

1. Remove the speculum!
2. Pressure with a scopette
3. Very rarely: Monsels or silver nitrate

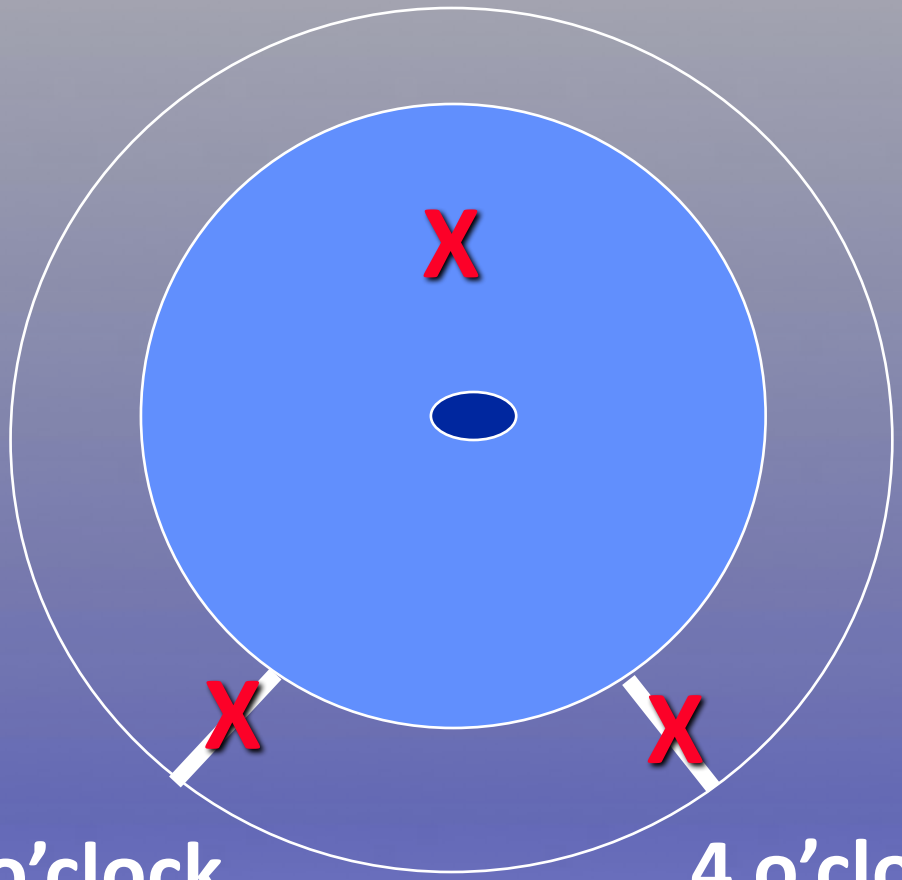
Paracervical Block



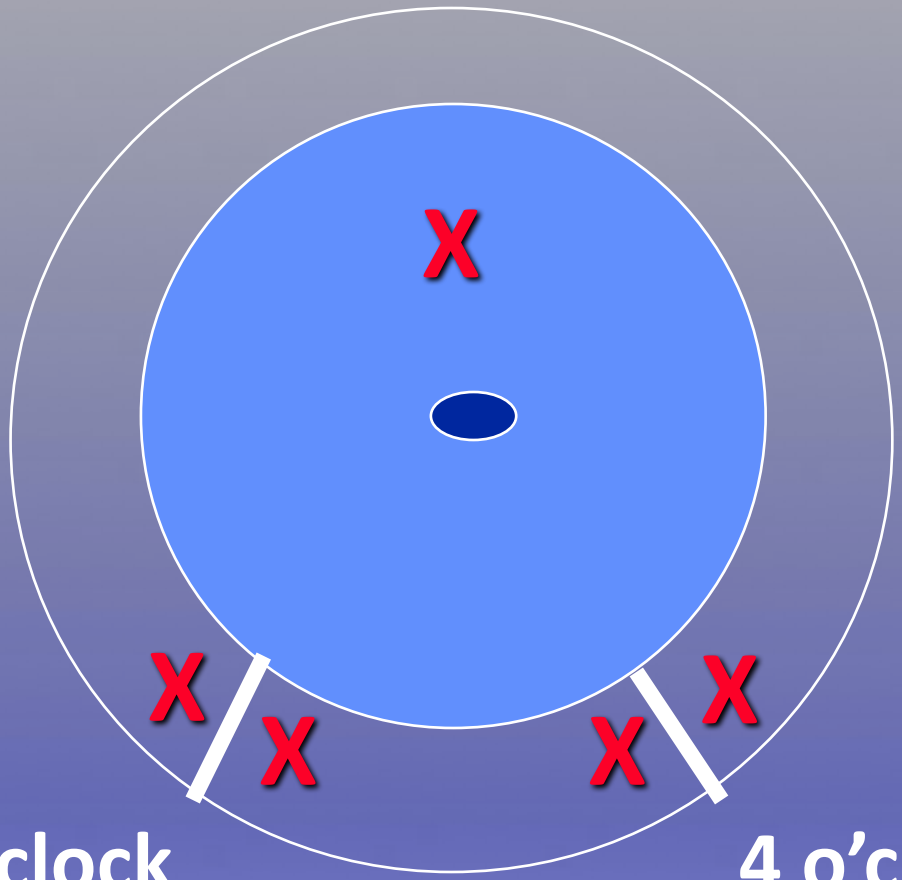
Paracervical Block

- Target is uterosacral ligaments
- Inject at reflection of cervico-vaginal epithelium
- Use spinal needle or 25g, 1 ½” needle + extender
- Shorter (Moore-Graves) speculum allows for more movement

Paracervical Block



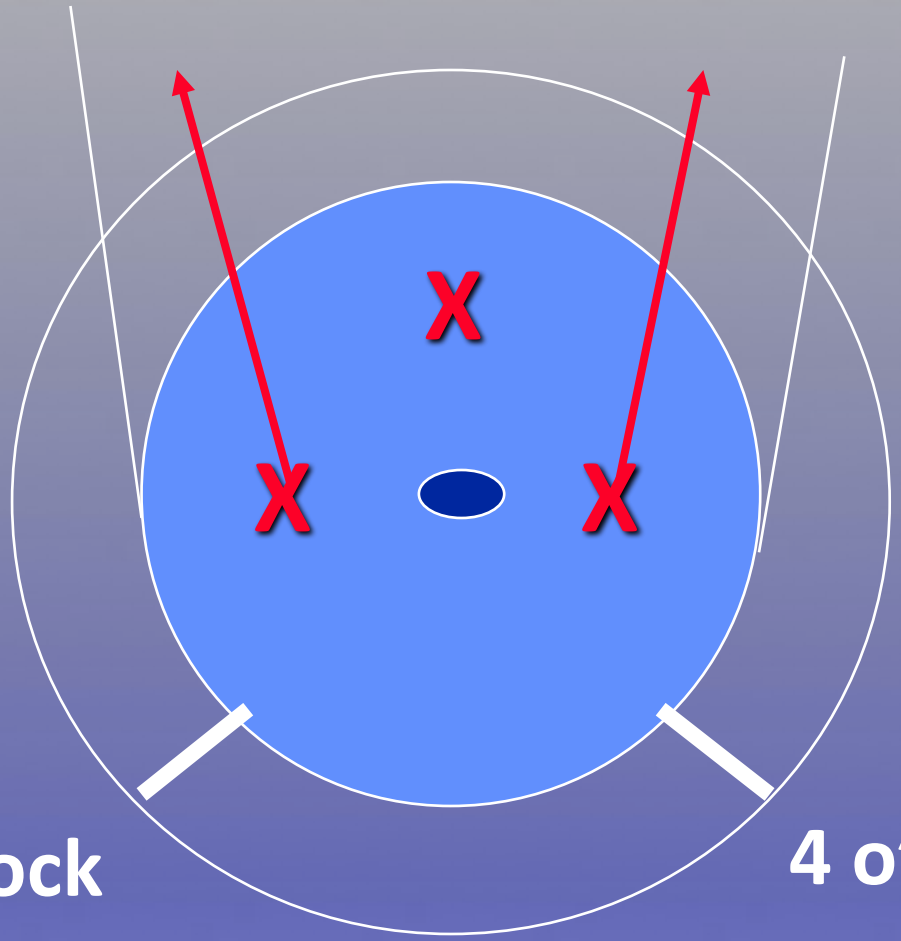
Paracervical Block



Intracervical Block

- Targets the paracervical nerve plexus
- 1 ½ inch 25g needle with 12 cc "finger lock" syringe
- Inject ½- 1 cc. local anesthetic at 12 o'clock, then apply tenaculum
- Angulate needle at the hub to 45° lateral direction
- At 3 or 9, insert needle into cervix *to the hub* 1 cm lateral to external os, aspirate
- Inject 4 cc of local, then last 1 cc while withdrawing
- Rotate barrel 180°, then inject opposite side

Intracervical Block



9 o'clock

3 o'clock

8 o'clock

4 o'clock

6 o'clock

Lidocaine Safety

- Inject in correct spot spot
- Draw back to avoid intravascular injection
- Possible metallic taste

Lidocaine Toxicity

- Central nervous system
  - Lightheadedness, restlessness, anxiety,
  - Tinnitus
  - Tremor, twitch
  - Perioral numbness
  - Visual changes
  - Seizure, respiratory arrest
- Cardiovascular
  - Bradycardia


MANAGEMENT

Any IUD: Initial Cramping Pain and/or Spotting

- It is normal for a woman to feel cramps, intermittent pelvic pain and any amount of spotting and light bleeding for a few weeks
- NSAIDS alleviate much or all of the cramping/pain
- Warm baths or warm packs
- Use clinical judgement to rule out other causes of pain and spotting

IUD Bleeding: An Adjustment Period

- These symptoms are expected, and normal and generally go away after the first few weeks
- The “worst is probably behind her”
- She has “weathered the storm”
- This is an “adjustment period” before years of protection

Responding To IUD Complaints and Side Effects

- Carol: Managing spotting with LnG IUD
- Susan: Managing heavier menses with CU IUD
- Gina: Partner can feel string

Carol 18 year old G_2 P_2 In Medical Assistant School

- LNG IUD 52mg placed 2 months ago
- “I love my IUD but I spot almost every day and it is starting to make me crazy!”
- “You told me I might have spotting or irregular bleeding but this seems like it’s not good for me.”

LNG IUD: Irregular Bleeding Or Spotting

- Some women have irregular bleeding for 3-4 months after placement:
  - Frequent spotting
  - Frequent light bleeding
  - *Rarely* heavier bleeding
  - Usually resolves after 3-4 months

- General pattern: amenorrhea or regular menses that get increasingly lighter with time

What is the Goal of Response to Carol?

- To get her to keep her IUD?
- Beware of your agenda vs. her agenda
- You are both on the same side… Hers

Responding to IUD-Related Complaints

- **All staff** gives similar messaging
- “Actively listen” to the patient’s complaint
- She doesn’t have to “fight for the right” to have her IUD removed
- Don’t assume the visit is for removal

Listen

- So you can understand *what outcome she wants*:

Does Carol want…

- To be reassured that she is not in danger?
- the problem *fixed?*
- to complain and be given compassion?
- advice?

Empathy Without Labeling

- Rather than…
  - "You sound anxious" or "angry"
- Use neutral words…
  - "It sounds like this constant spotting is quite concerning to you"
  - "I can see that spotting every day is really hard to deal with"

Empathy Traps

Avoid…

- Saying, “I know what you mean”
- Downplaying the significance of the concern or side effect

Rather…

“In the first few months using this IUD many of my patients feel that way”

“Anyone would find all that spotting to be a real drag!”

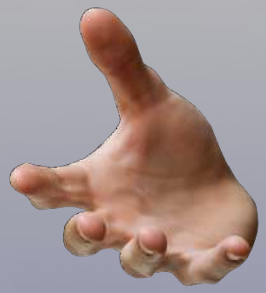
LNG IUD: Complaints Other than Bleeding

- The amount of progestin systemically absorbed is minimal
- Small possibility of progestin related side effects.
  - Weight gain, mood changes, acne, hair loss, headache
- *Very* rarely symptoms that are estrogen related
  - Breast tenderness and nausea
- The first step is to “actively listen” including use of re-phrasing

Susan G_1P_2 (twins)
29 year old Yoga Instructor

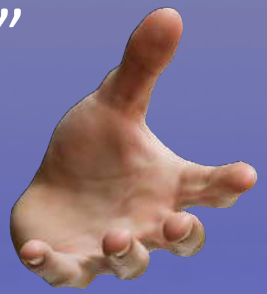
- Cu T placed 3 months ago
- “I love the fact that I am off hormones, but my periods are off the hook!”
- “I heard that this thing makes you bleed more and it sure does…”

On the One Hand- On the Other Hand



"So it sounds like on one hand you would like to continue with your IUD…

"And on the other hand, your periods are really an issue right now. Do I have that right?"



pause for a reply

Longer or Heavier Menses

NSAIDs prophylactically WITH FOOD

- Pre-emptive use for 1st 3 cycles
- Start before onset of menses
  - Naproxen sodium 220mg x2 BID (max 1100mg/d)
  - Ibuprofen 600-800mg TID (max 2400mg/day)

Credibility

- If a patient does not believe that you are knowledgeable about the “issues” with IUDs she may not trust you to help her with a solution to a complaint.

- She may just want it removed because you don’t know how *bad it is* or she doesn’t trust that your solution will work.

Intervention or Tincture of Time?

- Some complaints get better with time
- Others can be managed and improved with intervention (NSAIDs to mitigate bleeding with the copper IUD)
- It is helpful if **all staff** know that these options exist so that the message is consistent

If bleeding persists, or if the woman requests it, medical treatment can be considered.*

- **Cu-IUD users**
  - For unscheduled spotting or light bleeding or for heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
- **LNG-IUD users†**
- **Implant users†**
  - For unscheduled spotting or light bleeding or heavy/prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
- **Injectable (DMPA) users**
  - For unscheduled spotting or light bleeding:
    - NSAIDs (5–7 days of treatment)
  - For heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
- **CHC users (extended or continuous regimen)**
  - Hormone-free interval for 3–4 consecutive days
    - Not recommended during the first 21 days of extended or continuous CHC use
    - Not recommended more than once per month because contraceptive effectiveness might be reduced

If bleeding disorder persists or woman finds it unacceptable

Counsel on alternative methods and offer another method, if desired.

United States Selected Practice Recommendations for Contraceptive Use

US SPR

No Suppression of Endogenous Hormones with the Copper IUD

- A woman may experience sensations related to her own endogenous hormones
- Premenstrual bloating, breast pain, tenderness, or swelling, mood changes, low back pain, dysphoria or depression
- Sharp brief stabbing pain during the time of ovulation
- Ask for specific details about the premenstrual or other symptoms and offer treatment/management specific to the complaint.

Gina G_3P_3
"My Husband Can Feel The Strings … And It Hurt Him!"

- More likely if they are cut too short <3cm or >5cm
- 3-4 cm length is ideal
- Tuck them around the posterior lip of the cervix
- Threads soften with time in most cases
- Last resort is to trim threads up above the level of the external os
  - this is also indicated in cases of reproductive coercion

Betsy 17 year old G_0

- While having her LnG IUC placed, Betsy says, "Is this going to take much longer? I really need to go to the bathroom"
- What's going on here??

Betsy 17 year old G_0

- She recalls after the fact that she had a fainting spell after her HPV immunization
- She had told her PCP about this problem…heart auscultation and an ECG were normal.

Vasovagal Response, Episode Or Attack
AKA: Non-cardiogenic Syncope

- Mechanism
  - –Starts with peripheral vasodilation
  - –Bradycardia + drop in B/P
- More likely with
  - Pain with cervical manipulation
  - Previous episodes of vaso-vagal fainting

Grubb BP N Engl J Med 2005

  - Dehydration or NPO

Presyncopal Signs

- Facial pallor (distinct green hue)
- Yawning
- Pupillary dilatation
- Nervousness
- Diaphoresis
- Slurred or confused speech

Grubb BP N Engl J Med 2005

Presyncopal Symptoms

- Weakness/light-headedness
- Visual blurring/tunnel vision
- Nausea
- Feeling warm or cold
- Sudden need to go to the bathroom
- Tinnitus

Grubb BP N Engl J Med 2005

Vasovagal Prevention

- Good hydration (electrolyte/ sports drink)
- Eat before placement
- Prophylactically contract muscles if known history

Grubb BP N Engl J Med 2005

How to Abort a Vasovagal

- Isometric contractions of the extremities
- Intense gripping of the arm, hand, leg and foot muscles
- No need to bring the legs together or change position– just tense the muscles
- These contractions push blood back into the center of the body
- ….and abort the reflex

IUC Complications

	Absolute risk	Comment
Perforation	1/1,000	Mostly benign
Expulsion	1-6/100	Most are self-recognized
Unsuccessful placement	9/ 100	6% when different device is used after unsuccessful attempt
Pregnancy	<1/HWY	Minimal impact if removed early in pregnancy
PID	1-2/TWY	Same as gen'l population

HWY: per 100 women per year
TWY: per 1,000 women per year

Symptoms of Possible Complications

Symptom	Possible Explanation
Severe bleeding or abdominal cramping 3–5 days after insertion	Perforation, infection
Irregular bleeding and/or pain every cycle	Dislocation or perforation
Fever, chills, unusual vaginal discharge	Infection

more…

Symptoms of Possible Complications

Symptom	Possible Explanation
Pain during intercourse	Infection, perforation, partial expulsion
Missed period, other signs of pregnancy, expulsion	Pregnancy (uterine or ectopic)
Shorter, longer, or missing threads	Partial or complete expulsion, perforation

Management of Complications

- Jennifer: Perforation
- Rosa: Missing strings
- Sharonda: Pregnancy
- Donna: Pelvic infection

Jennifer 39 year old G_2 P_2 "What Was That Pain?"

- 6 wk post-partum visit (NSVD)…requests copper IUD
- Lactating, no longer bleeding
- Exam: 8-9 week size uterus; firm, non-tender
- During sounding, moderate resistance is encountered at the internal os…then sounded to 14 cm.
- She complained of pain only during the initial part of the sounding procedure
- What's going on here??

Postpartum IUC Insertion
US MEC 2010

Postpartum (BF or non-BF women) including C/S	LNG-IUS	Cu-IUD
<10 min after delivery of placenta	2	1
10 min after delivery of placenta to <4 wks	2	2
≥4 wks post partum	1	1
Puerperal sepsis	4	4

Uterine Perforation

- More likely to occur in relation to
  - Posterior uterine position
  - Post-partum placement, especially in lactating women
  - Skill/experience of provider
- Typical location is midline at uterine fundus…if so, perforation often is asymptomatic, benign
- Suspect if sounding is much deeper than expected or if ↑ resistance

Uterine Perforation Rates

European Active IUD Surveillance Study

- Multinational, prospective, non-interventional cohort study
- New IUD users
  - Baseline information
  - Follow-up at 12 months
    - User and clinician
  - Loss to follow-up 2%
- 61,448 women in 6 countries
  - 70.1% LNG; 29.9 copper (30 types)

Heinemann K, et al. *Contraception*. 2015

Uterine Perforation Rates

European Active IUD Surveillance Study

- Perforation: partial (20%); complete (80%)
- Perforation: 50% diagnosed first 2 months
- Perforation rates by 12 months
  - LNg: 1.4/1,000
  - Copper: 1.1/1,000
- Adjusted risk ratio for LNG: 1.6 (95% CI 1.0-2.7)
  - Adjusted for age, breastfeeding and pregnancy

Heinemann K, et al. *Contraception*. 2015

Uterine Perforation Rates

European Active IUD Surveillance Study

- Breastfeeding (BF) significantly increased risk
  - RR (BF vs non-BF): 6.1 (9.5% CI 3.9-9.6)
  - No difference between IUD types
- 63/81 perforations had risk factors
  - Breastfeeding
  - Time since delivery < 36 weeks
- No serious injury to intraperitoneal or pelvic structures

Heinemann K, et al. *Contraception*. 2015

Uterine Perforation Rates

European Active IUD Surveillance Study

Time Since Last Delivery	Breastfeeding		RR (95% CI)
	Yes	No	
≤ 36 weeks	*5.6*	*1.7*	3.3 (1.6-6.7)
> 36 weeks	*1.6*	*0.7*	2.2 (0.3-16)
RR (95% CI)	3.4 (0.5-24.8)	2.3 (1.1-4.7)	

Italicized numbers: perforation rate per/1000 insertions

Heinemann K, et al. *Contraception*. 2015

Factors That Didn't Affect Perforation Risk

European Active IUD Surveillance Study

- Cervical dilation at time of placement
- Use of anesthesia
- Ever cesarean section
- Last delivery by cesarean section

Heinemann K, et al. *Contraception*. 2015

Management of Uterine Perforation

- If *before* insertion of IUC, stop procedure
- If *during* insertion of IUC, remove IUC
- Monitor for 30 min for excessive bleeding, pain
- Provide alternative method of contraception
- Can insert another device after

Prevention of Uterine Perforation

- Move slowly and intentionally
- Avoid momentum; moving quickly increases momentum
- Once you have passed through the internal os—*STOP and pause for a second.*
- Then intentionally proceed to the fundus in a controlled fashion

Prevention of Perforation

You will feel resistance when the uterine sound touches the fundus

- This "fundal feel," or resistance should be a signal to STOP advancing the sound
- Never push beyond fundal resistance even if the flange is not yet at the external os

Prevention of Uterine Perforation

- Careful assessment of uterine position
- Exert adequate traction with the tenaculum to straighten the axis of the uterus
- Careful hand positioning when using the sound and the inserter
- Consider using a plastic sound
- Avoid excessive force during sounding and placement
- Do not use the white stabilizing rod as a plunger during placement of a copper IUC

Prevention of Uterine Perforation

- Place cervical block and dilate cervix if resistance is encountered
- Don't use inserter to sound; open IUC package only *after* sounding is completed

Rosa 50 yo G_3 P_3
"I Can't Feel The String"

- IUC inserted 8 years ago
- Remembers that it had a T shape, but not sure which type of IUC was inserted
- Hasn't been able to feel the string for the past 2 months, but before that checked irregularly
- String is not present at the external cervical os

Rosa 50 year old G_3 P_3

- Clinical dilemmas
  - Determination of IUC location
  - Extraction of IUC without visible string

IUD Without Strings

- What type of IUD is it?
- Does she desire pregnancy?
- Is she experiencing side effects?
- Does she want another contraceptive method?
- Review the benefits and risks of removal

Missing String…Possibilities

- IUC in-situ
  - String coiled in canal or endometrial cavity
  - String short, broken, or severed
- Unnoticed expulsion
- Intrauterine pregnancy

Missing String…Possibilities

- Malpositioning of the IUC, following perforation
  - Embedment into the myometrium
  - Translocation into the abdominal or pelvic cavity
- The perforation is not the problem; the abnormal position of the IUD is!

Missing IUC String: Expulsion

- Occurs in 2-10% IUC insertions within first year
- Risk of expulsion related to
  - Provider's skill at fundal placement
  - Age, parity, uterine configuration
  - Time since insertion (↑ within 6 mos)
  - Timing of insertion (menses, postpartum, post-abortion)

Missing IUC String: Expulsion

- Unnoticed expulsion may present with pregnancy
- Partial expulsion may present with
  - Pelvic pain, cramps, intermenstrual bleeding
  - IUC string longer than previously

Missing String: Pregnancy With IUC

- Determine site of pregnancy (IUP or ectopic)
- If termination planned, await TAB to avoid triggering spontaneous abortion (SAB)
- If continuing IUP and strings are not visible, do not attempt removal
  - Increase surveillance for SAB, pre-term birth
  - No greater risk of birth defects, since IUC is outside of the amniotic sac

Missing IUC String: Other Possibilities

- Translocation
  - Since copper IUC may cause more adhesions, must extract promptly via operative laparoscopy
  - LNG-IUS is less reactive, but most experts recommend laparoscopic removal

Missing IUC String: Other Possibilities

- In situ placement: desires retention
  - Leave in place for remainder of IUC lifespan
  - Option: annual pelvic ultrasound *in lieu* of string check

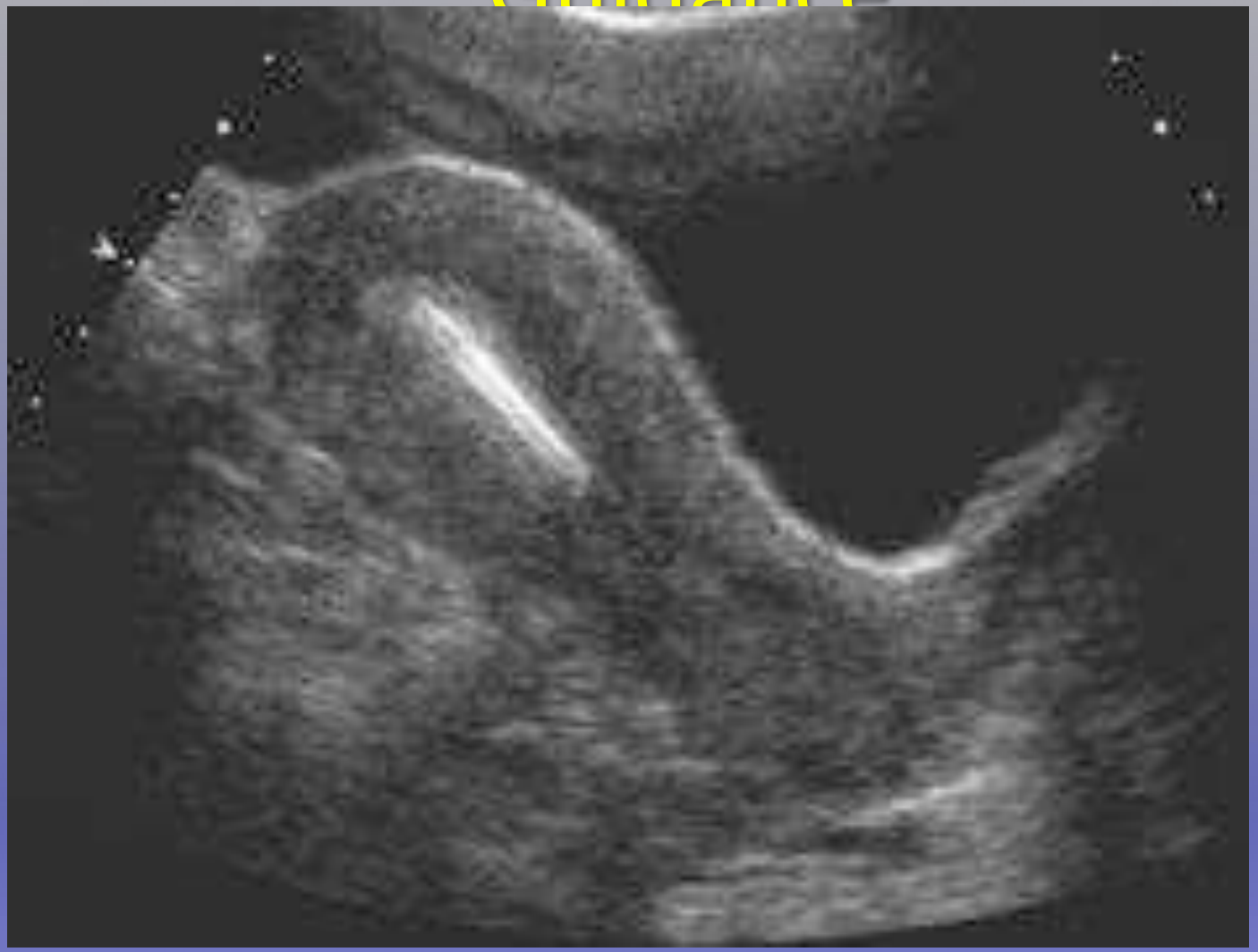
Missing IUD String: Initial Management

- Ask Rosa whether removal or retention is desired
- Assess pregnancy status with menstrual history or UPT
  - Positive: locate and date pregnancy
  - Negative: may attempt extraction

Missing IUD String: Initial Management

1. Sweep string from canal
2. Pregnant? → perform office UPT
   - Positive: locate and date pregnancy
   - Negative: go to #3
3. Office ultrasound, if available
   - No IUD in situ: order KUB
   - IUD in situ: go to #4
4. Retention desired?
   - Yes: may continue use
   - No: attempt extraction

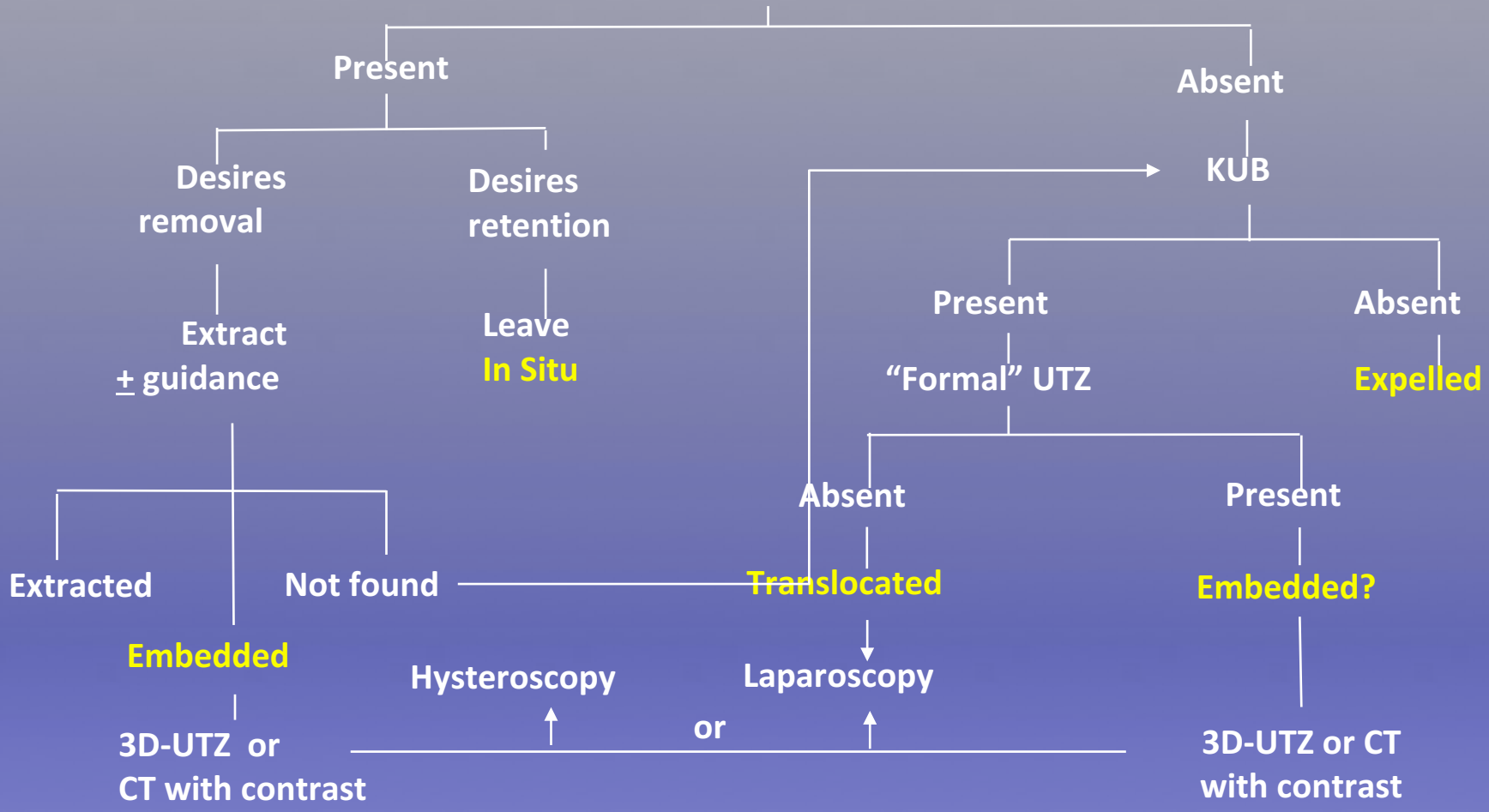
Missing IUD: Ultrasound Guidance



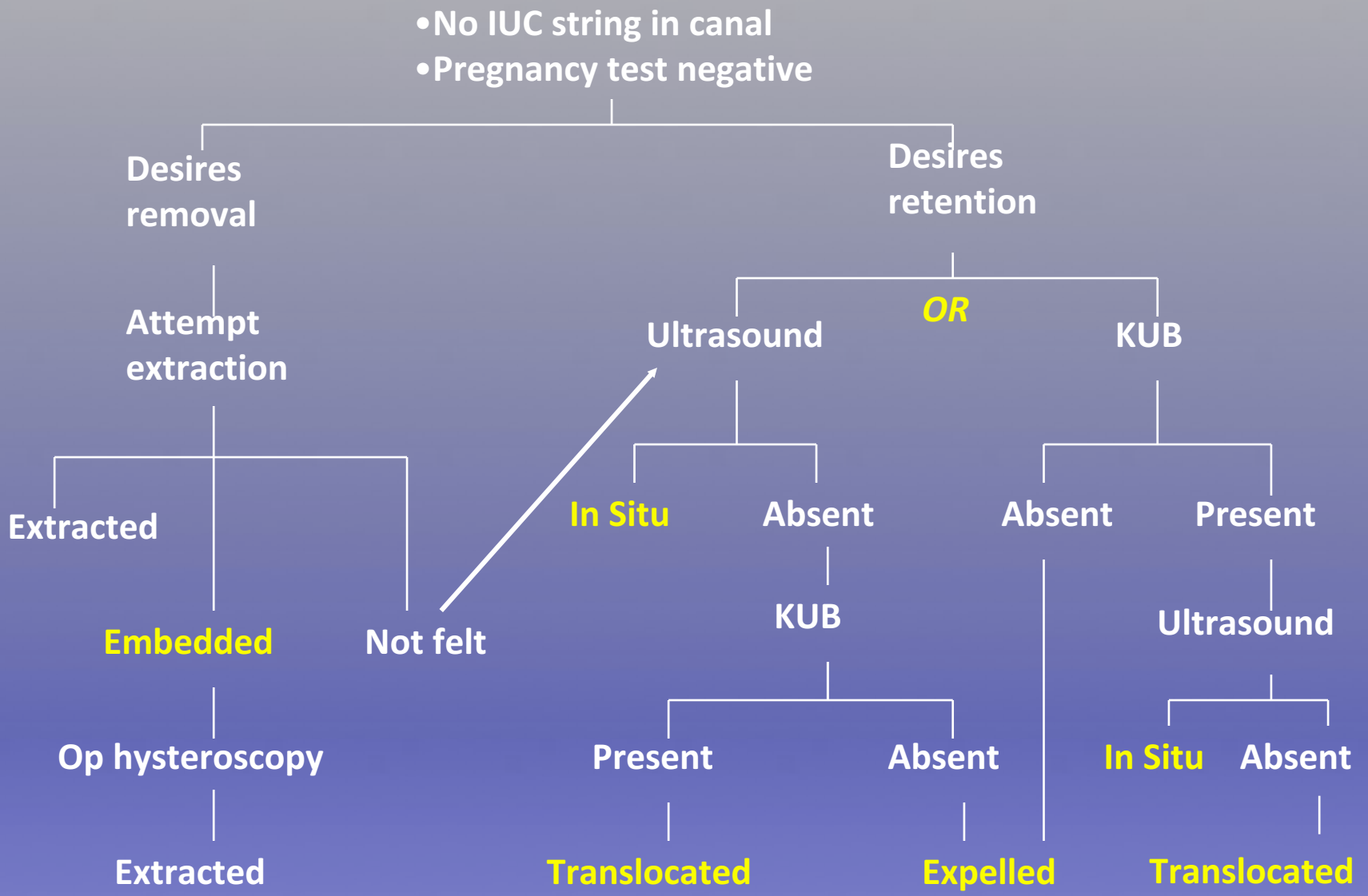
Carrie Cwiak, MD, MPH

Missing IUD String: Office Ultrasound

- No IUD string in canal
- Pregnancy test negative
- Office ultrasound (UTZ)



Office Ultrasound Not Used

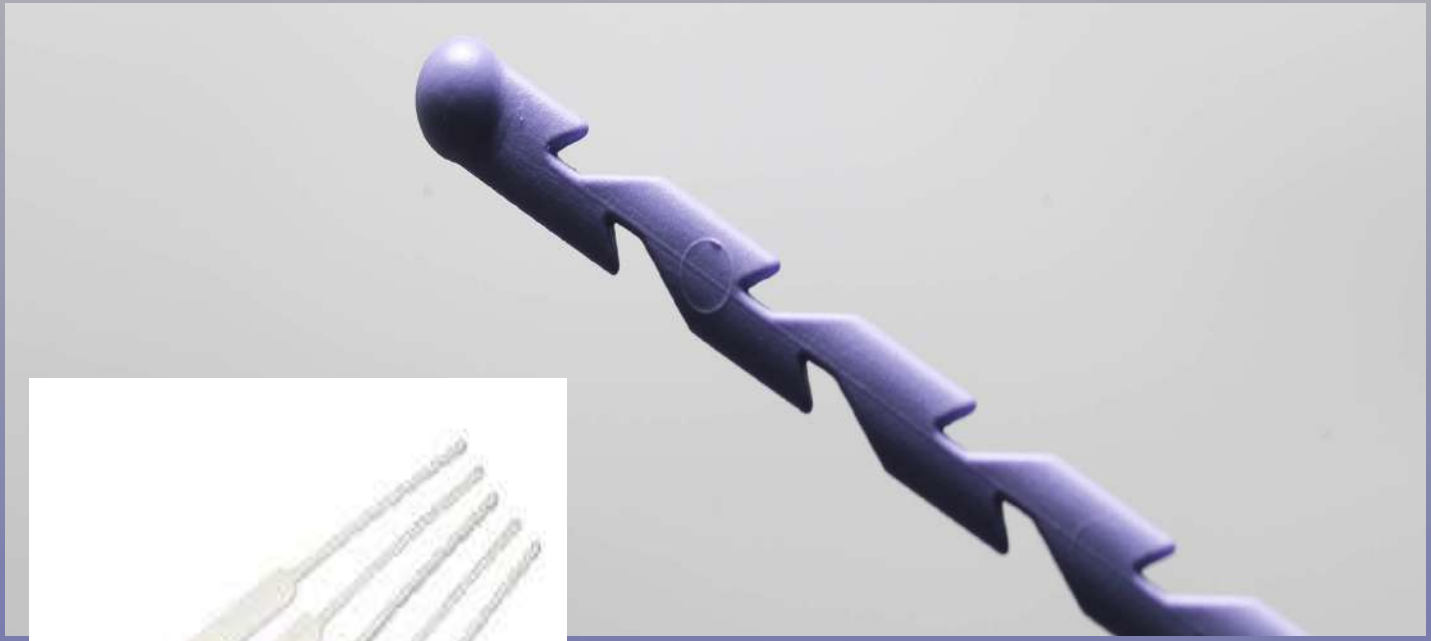


Missing IUD String: Desires Removal

Extraction of IUD in-situ

1. Consent fr uterine instrumentation procedure
2. Bimanual exam
3. Probe for strings in cervical canal
4. Apply tenaculum
5. Administer cervical block
6. Choose extraction device
   - Emmett Thread Retriever
   - Patterson alligator forceps
   - Ring IUD: crochet hook or 3-5 mm suction curette

Thread Retriever



Thread Retriever

Alligator forceps

Fulcrum 1 cm from the tip of the device

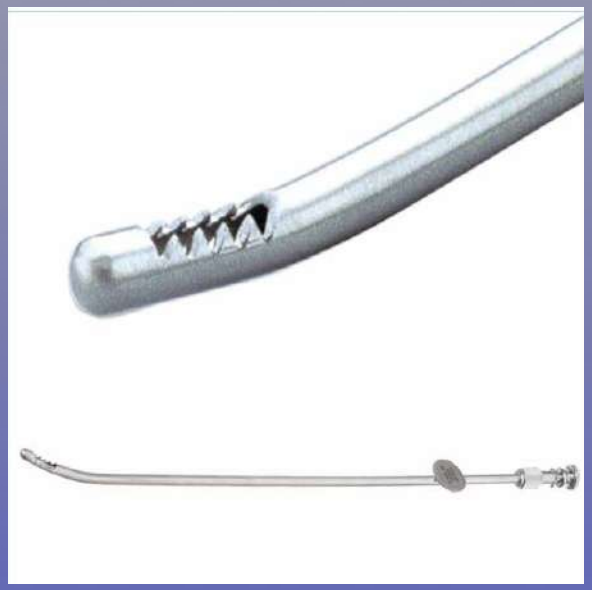
Opened and closed completely within the uterine cavity

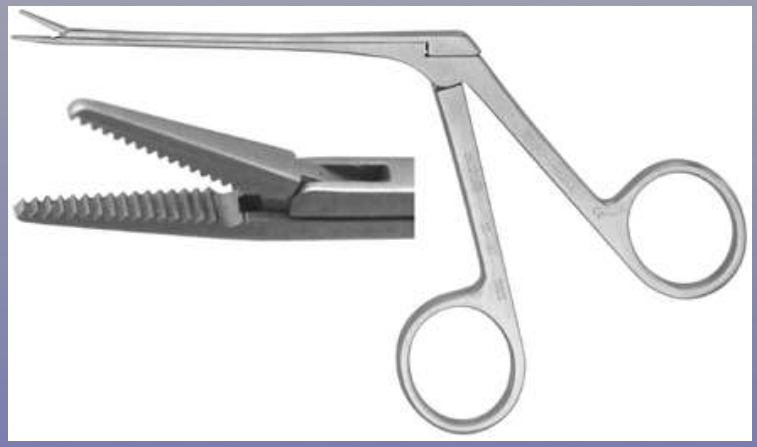
No cervical dilation necessary

Prabhakaran S, Chuang A, *Contraception* 2011.

IUD Removal Without Strings

Alternate





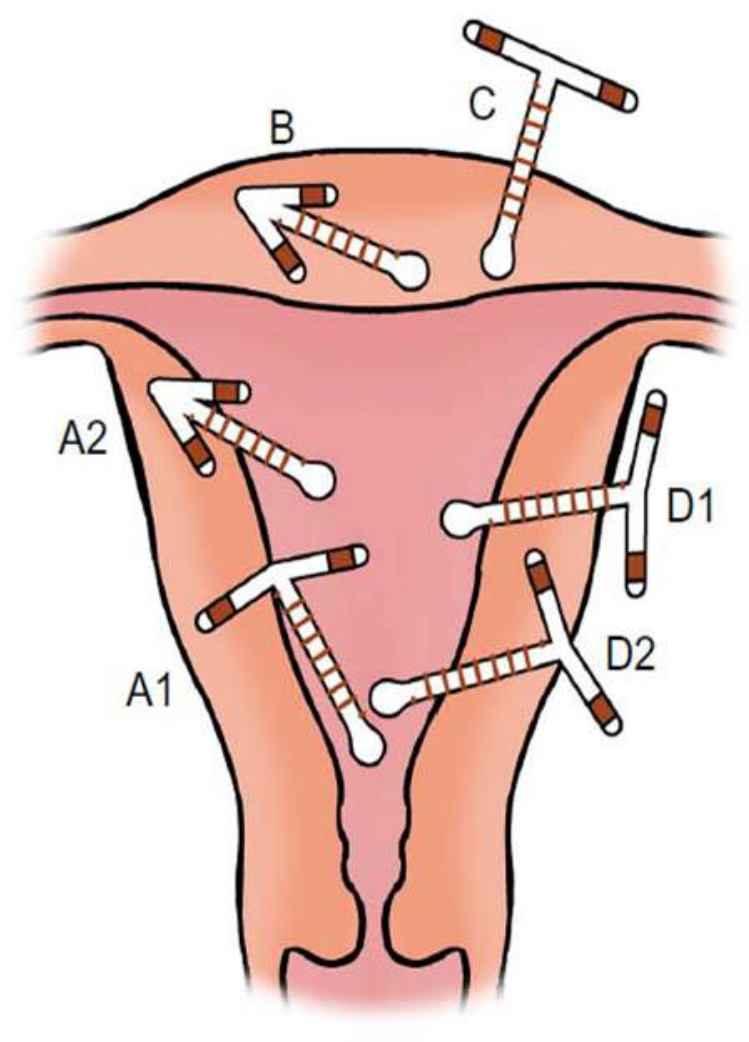
Carrie Cwiak, MD, MPH

Missing IUD String: Desires Removal

Extraction of IUD in-situ

7. Intrauterine exploration for a T-shaped IUD
   - Real-time ultrasound guidance may help, if available
   - Gently open/ close/quarter turn forceps at progressive depths until “purchase” of stem or arm
8. Maneuver hook along anterior, then posterior, uterine wall from fundus to canal
9. If embedment suspected, consider evaluation with 3-D ultrasound or pelvic CT with contrast
   - Extract via operative hysteroscopy or laparoscopy

Why Do CT or 3-D Ultrasound?



Answer:
To decide whether to start the extraction with laparoscopy or hysteroscopy!

Missing IUC String: Desires Removal

Additional measures, as indicated

- Pain management
  - Cervical block + oral NSAIDs for pain
  - Conscious sedation
- Cervical dilation
  - Osmotic dilator
  - Rigid dilators
  - Misoprostol *may* facilitate IUC extraction

IUC Removal in Menopausal Women

- Strings seen: remove
- No strings visible…weigh risks
  - Hazards of continuation (post-menopausal bleeding, ? pelvic actinomycosis)
  - Hazards of removal (pain, perforation)
- Tail-less IUC (e.g., Chinese stainless steel coil ring) should not be removed unless requested by the patient

Sharonda G3 P2

- Had a Cu IUD placed 6 months ago
- LMP 6 weeks ago
- Breast tenderness, nausea
- No pain or bleeding
- Positive pregnancy test
- Wants to continue the pregnancy

Pregnancy with IUC In Situ

- Determine if IUP or ectopic
- If intrauterine pregnancy confirmed
  - Counsel Sharonda on risks
  - Removal decreases risk of spontaneous abortion, premature delivery
  - If Sharonda consents:
    - Remove IUD if strings visible
    - (If she were planning termination: could remove IUD or await procedure)

Pregnancy With IUC In Situ

- If ectopic confirmed manage as with any other ectopic
- Could leave Cu IUD in situ

If Strings Not Visible; Retention Of IUC During Pregnancy

- Increase surveillance for SAB, pre-term birth
- No greater risk of birth defects (extra-amniotic)

Donna: Pelvic Infection with IUD in Place

- Placeholder for pelvic infection case study
- Cut and paste diagnosis and management from existing slides and/or SPR

PID in an IUD User

- Treat PID according to the CDC STD Treatment Guidelines
- Provide management for STDs
- Counsel about condom use
- The IUD does not need to be removed at time of treatment

PID in an IUD User

- Reassess in 48–72 hours
  - If no improvement, continue antibiotics and consider removal of the IUD
- If removal requested, do so after antibiotics started to avoid the risk of bacterial spread
- If the IUD is removed, consider ECPs if appropriate

STD Treatment Guidelines (p82)

Treatment outcomes did not generally differ between women with PID who retained the IUD and those who had the IUD removed

Actinomyces-Like Organisms (ALO)

- *Actinomyces israelii* has characteristics of both bacteria and fungus; part of GI flora
- May asymptomatically colonize the frame of the IUC, which in itself is not dangerous
- Very small percentage of women with IUC + actinomyces will develop *pelvic actinomycosis*
  - Presentation is similar to severe PID
- Women with ALO on Pap smear
  - Should be examined to exclude PID
  - If none, don't treat actinomyces or remove IUC

IUD Use in Women with HIV Infection

- No higher risk for overall or for infectious complications in HIV-infected women
- IUD use did not adversely affect progression of HIV when compared with hormonal contraceptive use
- IUD use among HIV-infected women was not associated with increased risk for transmission to sex partners

IUD Use in Women with HIV Infection

United States Medical Eligibility Criteria for Contraceptive Use

US MEC

	LNG Initiate	LNG Continue	Copper Initiate	Copper Continue
High risk for HIV infection	2	2	2	2
HIV infection	2	2	2	2
AIDS	3	2	2	2
Clinically well on ARV therapy	2	2	2	2

Postpartum IUD Placement

Placeholder for

- Add newer studies about post-partum IUD placement
- Add photos or line drawings of post-partum placement

Postpartum IUC Insertion
US MEC 2016

United States Medical Eligibility Criteria for Contraceptive Use

US MEC

Postpartum , including C/S	LNG-IUS	Cu-IUD
<10 min after delivery of placenta*	1-nonBF 2- BF	1
10 min after delivery of placenta to <4 wks*	2	2
≥4 wks post partum	1	1
Puerperal sepsis	4	4

- Higher rates of expulsion should be considered
- BF: women who are breast-feeding their newborn

How Is Postpartum IUC Insertion Done?

- IUC placement after vaginal delivery
  - Insert IUC within 15 minutes of placental delivery
  - Use sponge forceps on cervical lip; 2nd forceps to place IUC at uterine fundus
  - Cut string flush with external cervical os
- IUC placement at caesarean section
  - After delivery of newborn and placental removal…
  - Manually place IUC at fundus; tuck strings thru cervix
  - Repair uterus and complete c-section
  - Trim strings at postpartum visit

Title Slide:
Encounter Coding for IUD Services

Codes Numbers Tell A Story

	Encounter content	Code book
What	• Services performed • Drugs, supplies provided	• CPT • HCPCS II
Why	• Diagnoses	• ICD-#-CM
Additional Explanation	• Modifier	• CPT

- To establish medical necessity, for every *what* there must be a *why*
- Unusual circumstances explained with *modifier*

CPT Codes for Contraceptive Procedures

CPT	Description
58300	Insert IUD
58301	Remove IUD
11981	Insert non-biodegradable drug delivery implant
11982	Remove non-biodegradable drug delivery implant
11983	Removal with reinsertion of non-biodegradable drug delivery implant

HCPCS II: IUD J-Codes

HCPCS	National code description
J 7297	LN-releasing IUS, 52 mg, 5 year (Liletta)
J 7298	LN-releasing IUS, 52 mg, 5 year (Mirena)
J 7300	Intrauterine copper contraceptive (ParaGard)
J 7301	LN-releasing IUS , 13.5 mg (Skyla)

Encounter for Contraceptive Management

Z30.01 Encounter for initial prescription of contraceptives

ICD-10	Description
Z30.011	Initial prescription of contraceptive pill
Z30.012	Prescription of emergency contraception
Z30.013	Initial prescription of injectable contraception
Z30.014	Initial prescription of IUD (not insertion!)
Z30.018	Initial prescription of other contraceptives • Medi-Cal: use for implant insertion
Z30.019	Initial prescription of contraceptives, unspecified

Encounter for Contraceptive Management

Z30.4 Encounter for surveillance of contraceptives

ICD-10	Description
Z30.40	Surveillance of contraceptives, unspecified
Z30.41	Surveillance of contraceptive pills
Z30.42	Surveillance of injectable contraceptive
Z30.430	Insertion of IUD
Z30.431	Routine checking of IUD
Z30.432	Removal of IUD
Z30.433	Removal and reinsertion of IUD
Z30.49	Surveillance of other contraceptives • Medi-Cal: use for implant surveillance and removal

IUD Placement Modifiers

#	Definition	Possible Clinical Scenarios
-22	Increased procedural services	• Complex or difficult insertion
-25	Significant, separately identifiable E/M service	• Patient came in for general contraceptive counseling, ends up choosing IUD or implant, and it is inserted that day
-51	Multiple procedures on the same day, during the same session	• Removal of IUD and insertion of new IUD on the same day • Removal of implant and insertion of new implant on the same day

IUD Placement Modifiers

#	Definition	Possible Clinical Scenarios
-52	Failed procedure	• Provider couldn't complete procedure for anatomic reasons (eg. stenosis)
-53	Discontinued procedure	• Patient changed mind during procedure • Severe pain • Vasovagal • Clinician feels there is a threat to the patient's well-being and discontinues procedure
-76	Repeat procedure	• Successful insertion but the IUD is expelled, followed by repeat insertion

Case Study 1: STI Check and IUS Insertion

- Mr. L is 19 year-old established client who presents with concerns about STI and wants to be tested
- She also received contraceptive counseling (10 minutes); asked to have a 3 year LN-IUS inserted
- Samples sent for GC/CT NAAT, HIV serology
- Office urine pregnancy test negative
- Bimanual exam performed; then IUS inserted easily
- Pelvic ultrasound with vaginal probe to check placement

ACOG on CPT + E/M Visit

- If she states “I want an IUD,” followed by discussion, consent, and placement, an E/M code is not reported
- If all options are discussed and an implant or IUD is placed, an E/M and CPT codes may be reported
- If seen for another reason and a procedure is performed, E/M and CPT codes may be reported (turn-around visit)

ACOG; LARC Quick Coding Guide

ACOG on CPT + E/M Visit

- Modifier -25 added to *the E/M code*
- If reporting E/M and CPT code, documentation must indicate a "significant, separately identifiable" service
  - E/M level using "3 key components" or time

ACOG; LARC Quick Coding Guide

ACOG on Ultrasound with IUD Insertion

- An ultrasound to check IUD placement is not bundled into the IUD insertion (code 58300), and it is not common practice to use ultrasound to confirm placement. This should not be billed.
- Ultrasonography may be used to confirm the location when the clinician incurs *a difficult IUD placement* (e.g., severe pain)
  - Code 76857 Ultrasound, pelvic, limited or follow-up, or
  - Code 76830 Ultrasound, transvaginal
- Occasionally, ultrasound is needed to guide IUD insertion. Code 76998 (Ultrasonic guidance, intraoperative)

ACOG; LARC Quick Coding Guide

Case Study 1: Answer

	CPT/ HCPCS II Code	ICD-10-CM Code
Procedure	58300 Insert IUD	Z30.430 Insertion of IUC
Supply	Check with payer	
Drug	J7301 LNG-IUS, 13.5 mg	Z30.430 Insertion of IUC
Lab	81025 UPT	Z32.02 Preg exam or test, negative
E/M	99212	Z 30.09 Other FP advice
Modifier	99212-25	

- -25 indicates that a significant and separately identifiable E/M was provided on the same date of service as a procedure

Case 2: IUD Removal and Implant Insertion

- Ms. P, an established patient, sees Dr. Q
- She had an IUD inserted 5 years ago but is now experiencing bleeding and cramping
- Dr. Q does an expanded problem-focused exam and takes additional history
- They discuss removal of the IUD and other possible contraceptive methods.
- After a brief discussion, Ms. P requests an implant
- Dr. Q removes the IUD and inserts an implant

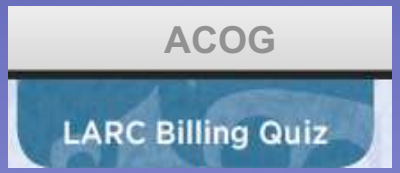
Case Study 2: Answer

	CPT code	ICD-10-CM code
Procedure	11981 (implant insertion)	Z30.018 (implant insertion)
	58301-51 (IUD removal)	Z30.432 (IUD removal)
Supplies	Check with payer for IUC removal, none for implant	
Drug	J7307 (ETG implant)	Z30.018
Lab	None	
E/M	99212 or 99213	N92.6 (Irreg.menstruation)
Modifier	11981-51	

- Code 11981 reported 1st because it has higher RVU (2.67 vs. 2.54)
- Modifier 51 (multiple procedures) is added to the lesser procedure

Case 3: Difficult IUC Insertion

- Ms. T sees Dr. U, and requests insertion of a copper intrauterine contraceptive
- Ms. T weighs 220 lbs and has a BMI of 40.2
- Dr. U inserts an IUD with some difficulty due to Ms. T's body habitus
- How should Dr. U code for this visit?



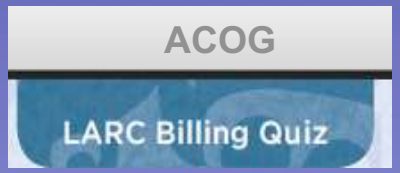
Case Study 3: Answer

	CPT code	ICD-10-CM code
Procedure	58300 (IUD insertion)	Z30.430 (insertion of IUD) Z68.41 (BMI of 40-44.9)
Supply	Check with payer for IUC insertion	
Drug	J7300 (copper IUC)	Z30.430
Lab	None	
E/M	None	
Modifier	58300-22	

- Dr. U documents the additional work, complexity, and risk to the patient to support use of the modifier – 22
- Include med record note or explain in claim "remarks box"

Case Study 4: Discontinued IUC Insertion

- Ms. X, a new patient, requests insertion of an IUD
- After consent, Dr. Y attempts to insert a copper IUD
- Dr. Y tries to insert the IUC several times, but the patient has a stenotic cervical os and having pain. Dr. Y desists
- Dr. Y discusses other methods of contraception with Ms. X and she decides to try OCs
- This conversation lasts 20 minutes. The total time of the office visit was 35 minutes



Modifier-52 vs. Modifier-53
Failed or Discontinued Procedures

- Modifier-52 (reduced services): procedure is started but can't be finished for technical reasons
  - Essure procedure: 1 coil successfully placed in one tube but the second could not be placed EMB attempted but not completed 2º to stenosis
- Modifier -53 (discontinued procedure) owing to concerns regarding patient toleration of the procedure
  - Vaso-vagal episode during sounding
  - Perforation during IUD insertion

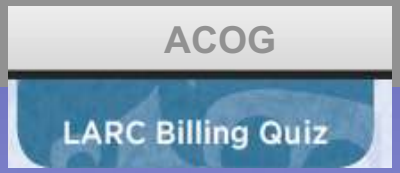
Case Study 4: Answer

	CPT code	ICD-10-CM code
Procedure	58300 IUC insertion	Z30.430 (IUD Insertion)
Supply or Drug	J7300 (intrauterine copper contraceptive)	Z30.430 (IUD Insertion)
Lab	None	
E/M	99203-25 (new patient office visit) for counseling	Z30.09 Encounter for other general counseling and advice on contraception
Modifier	58300-53	

- **Modifier -53 indicates that the procedure was attempted but discontinued because of pain**

Case 5: Post-SAB IUC Insertion

- Ms. N is 10 weeks pregnant and sees Dr. O because of vaginal bleeding
- She had seen Dr. O previously for obstetric care
- Dr. O performs an exam, asks questions, and performs a limited ultrasound
- She decides Ms. O is having a miscarriage and suggests immediate treatment
- Ms. N also requests insertion of a copper IUD
- Dr. O completes the miscarriage surgically and inserts an IUD during this visit



Case Study 5: Answer

	CPT code	ICD-10-CM code
Procedure	59812 (incomplete abortion completed surgically)	O03.39 (Incomplete spontaneous abortion with other complications)
	58300-51 (IUD insert)	Z30.430 (insertion of IUD)
	76817 (transvag UTZ)	O03.39
Drug	J7300 (copper IUD)	Z30.430
Supplies	Check with payer	
Lab	Rh type	
E/M	None	
Modifier	None	

Advanced Cases

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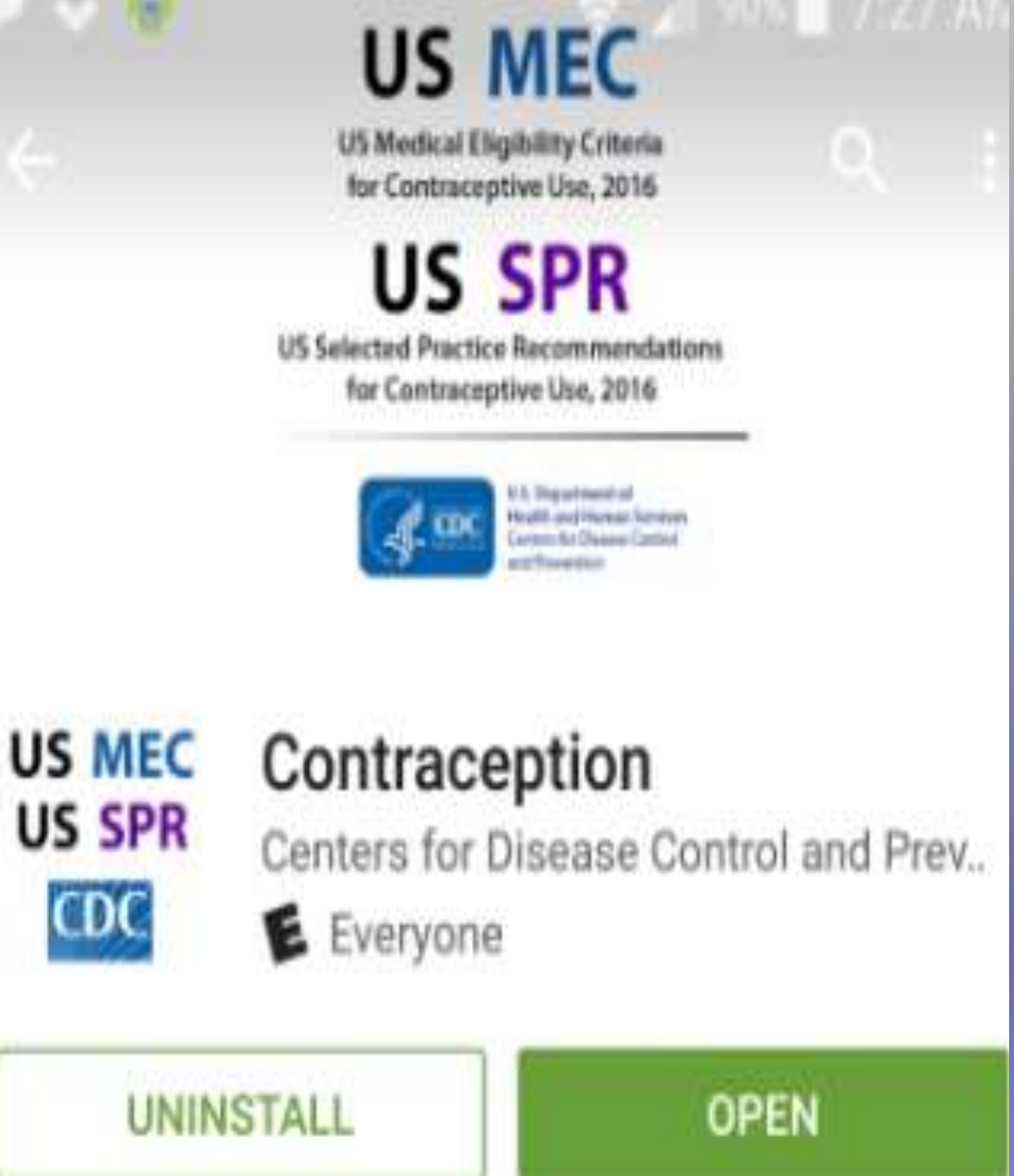

2016 CDC MEC and SPR phone app

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Disclosures

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- Advisory Board/Consultant
  - Teva, Merck, Bayer, ContraMed, Medicines 360
- Trainer/speaker
  - Merck, Medicines 360, Teva, ContraMed

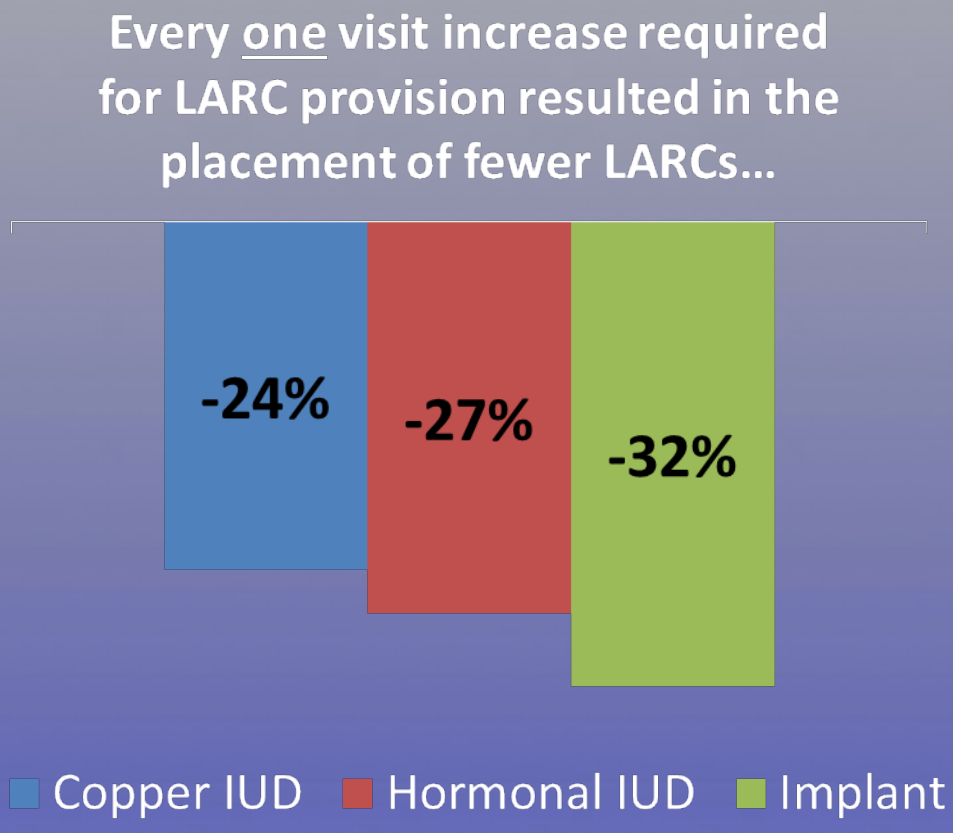
Outline

1. Efficient practices for same-day placement of IUDs
2. IUD counseling tips, including optimal language during client counseling
3. Nuances of informed consent…terms to explain to possibility of…

Same Day IUD Placement

More Visits → Fewer Patients Getting Method of Choice

National Clinical Training Center for Family Planning online survey of APRNs (n=390)



Source: National Clinical Training Center: Findings from a National APRN LARC Survey. Presented at the National Family Planning and Reproductive Health Association Meeting April 19, 2016

Provider Misconceptions

- "GC and CT screening test results are necessary"
  - Routine screening not indicated
  - If indicated, can be done at time of placement
- "IUDs can be placed only with menses"
  - Anytime if reasonably certain that not pregnant
- "Adolescents or women with multiple sexual partners are not candidates for IUD"

Office Practice Logistics

- "Placement adds too much time to a scheduled visit"
  - Adds no more than 5-10 minutes if each exam room is well stocked and the staff is prepared
- "Placement only at scheduled placement visits"
  - Any clinic visit is a potential placement visit
    - Well woman visit
    - Post-partum visits
    - Pregnancy test visits

Payment Barriers

- "IUD can be placed only after delivery from a PBM"
  - Keep extra insertion kits in the office
  - Replenish with the kit delivered from PBM
- "Method counseling and placement cannot be billed on the same date of service"
  - It definitely can be done...see ACOG and UCSF "Beyond the Pill" billing guides

Barriers to Same Day Placement

- Provider(s) not trained or confident of abilities
- Provider misconceptions
- Office practice logistics
- Payment misconceptions

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Choosing Which IUD

Brand Name	Skyla®	Kyleena®	Mirena®	Liletta®
LNG content (mg in reservoir)	13.5	19.5	52	52
Release rate (mcg/24 hrs) -- at end of life	14 5	17.5 7.4	20 +/- 10	19.5 17, 14.8, 12.9, 11.3, 9.8
Max duration, years	3	5	5 (7)	3 (5-7)
T-frame, mm	28 x 30	28 x 30	32 x 32	32 x 32
Insertion tube diameter	3.80	3.80	4.40	4.80
String color	Brown	Blue	Brown	Blue
Silver ring	Yes	Yes	No	No

Particular Characteristics Of IUDs

- Do you have a sense of what is important to you about your method?
- Do you have a sense of what you are looking for in a contraceptive method?

Elicit Her Attitudes About

- Effectiveness
- Hormones
- Menstrual cycle and bleeding profile
- Length of use
- Control over removal
- Object in her body
- Return to fertility
- Non-contraceptive benefits
- Side effects

Re-phrasing

- “So I hear you saying …(you really like the idea of using a method without hormones) do I have that right?”

- “It sounds like….(it’s super important to you have a method that you can rely on) is that what you mean?”

Amenorrhea with LNG IUD

Don't…

- Assume you know why she objects to amenorrhea
- Ask her "why"

Do…

- Ask what about not getting her period is concerning to her
- Let her know many women feel that way

Meena 29 G1P1
"What is it about not getting your period that is concerning to you?"

"I would always worry that I might be pregnant"

"I can see that it's very important to you not to get pregnant until you are ready"

"Many of my patients like to get their period every month because they feel like it lets them know they aren't pregnant"

Meena 29 G1P1

“Interestingly many women still bleed in the beginning of a pregnancy...”

“Pregnancy tests at the 99 cent store are plentiful and can be very reassuring!”

Natural Frequencies

"If a woman switches from the pill to an IUD her chance of unintended pregnancy is reduced from 90 in 1000 to <2 in 1000"

"If 100 women have unprotected sex for a year, 85 of them will get pregnant as opposed to none or maybe one out of 100 using a hormonal IUD"

Not:

"<1 % failure"

Kristal 22 G2P1
"My mom said it's not healthy not to get my period"

"Your mother is completely right!.... when you are not on contraceptive hormones it is important to get you period every month, it's great that you know that"

"I'm so glad you know that when you are not on contraceptive hormones and you miss your period you need to come in so we can see what's up!"

Kristal 22 G2P1
"My mom said it's not healthy not to get my period"

"I wish all of my patients knew that if they miss their period and they aren't on contraceptive hormones it could mean something is wrong!"

... "Interestingly, if a woman *is* using contraceptive hormones it keeps her uterus very healthy and thin. It actually prevents cancer of the uterus" (Show a picture)

Ask a question

“Knowing that, how would it be for you not getting periods?”

Nuances of Informed Consent

Informed Consent

- Expulsion
- Infection
- Perforation
- Method failure (pregnancy)

Obesity: The Right Speculum

- Too narrow--will not allow for good visualization
- Increase *width rather than length*
  - Avoid a long speculum
  - It can firmly splint the cervix in place
  - Does not allow you adequate cervical mobility to straighten the uterine flexion when using a tenaculum

Any IUD: Initial Cramping Pain and/or Spotting

- It is normal for a woman to feel cramps, intermittent pelvic pain and any amount of spotting and light bleeding for a few weeks
- NSAIDS alleviate much or all of the cramping/pain
- Warm baths or warm packs
- Use clinical judgement to rule out other causes of pain and spotting

IUD Bleeding: An Adjustment Period

- These symptoms are expected, and normal and generally go away after the first few weeks
- The “worst is probably behind her”
- She has “weathered the storm”
- This is an “adjustment period” before years of protection

Responding To IUD Complaints and Side Effects

- Carol: Managing spotting with LnG IUD
- Susan: Managing heavier menses with CU IUD
- Gina: Partner can feel string

LNG IUD: Irregular Bleeding Or Spotting

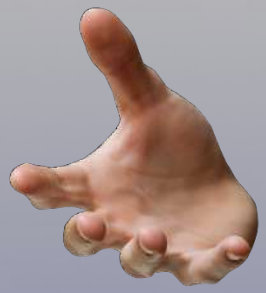
- Some women have irregular bleeding for 3-4 months after placement:
  - Frequent spotting
  - Frequent light bleeding
  - *Rarely* heavier bleeding
  - Usually resolves after 3-4 months

- General pattern: amenorrhea or regular menses that get increasingly lighter with time

LNG IUD: Complaints Other than Bleeding

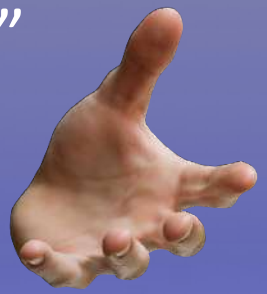
- The amount of progestin systemically absorbed is minimal
- Small possibility of progestin related side effects.
  - Weight gain, mood changes, acne, hair loss, headache
- *Very* rarely symptoms that are estrogen related
  - Breast tenderness and nausea
- The first step is to “actively listen” including use of re-phrasing

On the One Hand- On the Other Hand



"So it sounds like on one hand you would like to continue with your IUD…

"And on the other hand, your periods are really an issue right now. Do I have that right?"



pause for a reply

Longer or Heavier Menses

NSAIDs prophylactically WITH FOOD

- Pre-emptive use for 1st 3 cycles
- Start before onset of menses
  - Naproxen sodium 220mg x2 BID (max 1100mg/d)
  - Ibuprofen 600-800mg TID (max 2400mg/day)

If bleeding persists, or if the woman requests it, medical treatment can be considered.*

- **Cu-IUD users**
  - For unscheduled spotting or light bleeding or for heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
- **LNG-IUD users†**
- **Implant users†**
  - For unscheduled spotting or light bleeding or heavy/prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
- **Injectable (DMPA) users**
  - For unscheduled spotting or light bleeding:
    - NSAIDs (5–7 days of treatment)
  - For heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
- **CHC users (extended or continuous regimen)**
  - Hormone-free interval for 3–4 consecutive days
    - Not recommended during the first 21 days of extended or continuous CHC use
    - Not recommended more than once per month because contraceptive effectiveness might be reduced

If bleeding disorder persists or woman finds it unacceptable

Counsel on alternative methods and offer another method, if desired.

United States Selected Practice Recommendations for Contraceptive Use

US SPR

Vasovagal Response, Episode Or Attack
AKA: Non-cardiogenic Syncope

- Mechanism
  - –Starts with peripheral vasodilation
  - –Bradycardia + drop in B/P
- More likely with
  - Pain with cervical manipulation
  - Previous episodes of vaso-vagal fainting

Grubb BP N Engl J Med 2005

  - Dehydration or NPO

Presyncopal Signs

- Facial pallor (distinct green hue)
- Yawning
- Pupillary dilatation
- Nervousness
- Diaphoresis
- Slurred or confused speech

Grubb BP N Engl J Med 2005

Presyncopal Symptoms

- Weakness/light-headedness
- Visual blurring/tunnel vision
- Nausea
- Feeling warm or cold
- Sudden need to go to the bathroom
- Tinnitus

Grubb BP N Engl J Med 2005

Vasovagal Prevention

- Good hydration (electrolyte/ sports drink)
- Eat before placement
- Prophylactically contract muscles if known history

Grubb BP N Engl J Med 2005

How to Abort a Vasovagal

- Isometric contractions of the extremities
- Intense gripping of the arm, hand, leg and foot muscles
- No need to bring the legs together or change position– just tense the muscles
- These contractions push blood back into the center of the body
- ….and abort the reflex

IUD Use in Women with HIV Infection

- No higher risk for overall or for infectious complications in HIV-infected women
- IUD use did not adversely affect progression of HIV when compared with hormonal contraceptive use
- IUD use among HIV-infected women was not associated with increased risk for transmission to sex partners

How Is Postpartum IUC Insertion Done?

- IUC placement after vaginal delivery
  - Insert IUC within 15 minutes of placental delivery
  - Use sponge forceps on cervical lip; 2nd forceps to place IUC at uterine fundus
  - Cut string flush with external cervical os
- IUC placement at caesarean section
  - After delivery of newborn and placental removal…
  - Manually place IUC at fundus; tuck strings thru cervix
  - Repair uterus and complete c-section
  - Trim strings at postpartum visit

Encounter Coding for IUD Services

Codes Numbers Tell A Story

	Encounter content	Code book
What	• Services performed • Drugs, supplies provided	• CPT • HCPCS II
Why	• Diagnoses	• ICD-#-CM
Additional Explanation	• Modifier	• CPT

- To establish medical necessity, for every *what* there must be a *why*
- Unusual circumstances explained with *modifier*

CPT Codes for Contraceptive Procedures

CPT	Description
58300	Insert IUD
58301	Remove IUD
11981	Insert non-biodegradable drug delivery implant
11982	Remove non-biodegradable drug delivery implant
11983	Removal with reinsertion of non-biodegradable drug delivery implant

HCPCS II: IUD J-Codes

HCPCS	National code description
J 7297	LNG-releasing IUS, 52 mg, (Liletta)
J 7298	LNG-releasing IUS, 52 mg, (Mirena)
J 7300	Intrauterine copper contraceptive (PARAGARD)
J 7301	LNG-releasing IUS , 13.5 mg (Skyla)

Encounter for Contraceptive Management

Z30.01 Encounter for initial prescription of contraceptives

ICD-10	Description
Z30.011	Initial prescription of contraceptive pill
Z30.012	Prescription of emergency contraception
Z30.013	Initial prescription of injectable contraception
Z30.014	Initial prescription of IUD (not insertion!)
Z30.018	Initial prescription of other contraceptives • Medi-Cal: use for implant insertion
Z30.019	Initial prescription of contraceptives, unspecified

Encounter for Contraceptive Management

Z30.4 Encounter for surveillance of contraceptives

ICD-10	Description
Z30.40	Surveillance of contraceptives, unspecified
Z30.41	Surveillance of contraceptive pills
Z30.42	Surveillance of injectable contraceptive
Z30.430	Insertion of IUD
Z30.431	Routine checking of IUD
Z30.432	Removal of IUD
Z30.433	Removal and reinsertion of IUD
Z30.49	Surveillance of other contraceptives • Medi-Cal: use for implant surveillance and removal

IUD Placement Modifiers

#	Definition	Possible Clinical Scenarios
-22	Increased procedural services	• Complex or difficult insertion
-25	Significant, separately identifiable E/M service	• Patient came in for general contraceptive counseling, ends up choosing IUD or implant, and it is inserted that day
-51	Multiple procedures on the same day, during the same session	• Removal of IUD and insertion of new IUD on the same day • Removal of implant and insertion of new implant on the same day

IUD Placement Modifiers

#	Definition	Possible Clinical Scenarios
-52	Failed procedure	• Provider couldn't complete procedure for anatomic reasons (eg. stenosis)
-53	Discontinued procedure	• Patient changed mind during procedure • Severe pain • Vasovagal • Clinician feels there is a threat to the patient's well-being and discontinues procedure
-76	Repeat procedure	• Successful insertion but the IUD is expelled, followed by repeat insertion

ACOG on CPT + E/M Visit

- If she states “I want an IUD,” followed by discussion, consent, and placement, an E/M code is not reported
- If all options are discussed and an implant or IUD is placed, an E/M and CPT codes may be reported
- If seen for another reason and a procedure is performed, E/M and CPT codes may be reported (turn-around visit)

ACOG; LARC Quick Coding Guide

ACOG on CPT + E/M Visit

- Modifier -25 added to *the E/M code*
- If reporting E/M and CPT code, documentation must indicate a "significant, separately identifiable" service
  - E/M level using "3 key components" or time

ACOG; LARC Quick Coding Guide

ACOG on Ultrasound with IUD Insertion

- An ultrasound to check IUD placement is not bundled into the IUD insertion (code 58300), and it is not common practice to use ultrasound to confirm placement. This should not be billed.
- Ultrasonography may be used to confirm the location when the clinician incurs *a difficult IUD placement* (e.g., severe pain)
  - Code 76857 Ultrasound, pelvic, limited or follow-up, or
  - Code 76830 Ultrasound, transvaginal
- Occasionally, ultrasound is needed to guide IUD insertion. Code 76998 (Ultrasonic guidance, intraoperative)

ACOG; LARC Quick Coding Guide

Case Study 1: Answer

	CPT/ HCPCS II Code	ICD-10-CM Code
Procedure	58300 Insert IUD	Z30.430 Insertion of IUC
Supply	Check with payer	
Drug	J7301 LNG-IUS, 13.5 mg	Z30.430 Insertion of IUC
Lab	81025 UPT	Z32.02 Preg exam or test, negative
E/M	99212	Z 30.09 Other FP advice
Modifier	99212-25	

- -25 indicates that a significant and separately identifiable E/M was provided on the same date of service as a procedure

Case Studies

Case 2: IUD Removal and Implant Insertion

- Ms. P, an established patient, sees Dr. Q
- She had an IUD inserted 5 years ago but is now experiencing bleeding and cramping
- Dr. Q does an expanded problem-focused exam and takes additional history
- They discuss removal of the IUD and other possible contraceptive methods.
- After a brief discussion, Ms. P requests an implant
- Dr. Q removes the IUD and inserts an implant

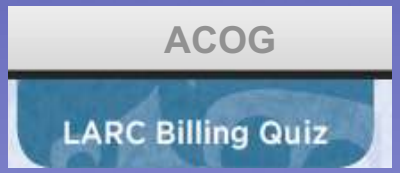
Case Study 2: Answer

	CPT code	ICD-10-CM code
Procedure	11981 (implant insertion)	Z30.018 (implant insertion)
	58301-51 (IUD removal)	Z30.432 (IUD removal)
Supplies	Check with payer for IUC removal, none for implant	
Drug	J7307 (ETG implant)	Z30.018
Lab	None	
E/M	99212 or 99213	N92.6 (Irreg.menstruation)
Modifier	11981-51	

- Code 11981 reported 1st because it has higher RVU (2.67 vs. 2.54)
- Modifier 51 (multiple procedures) is added to the lesser procedure

Case 3: Difficult IUC Insertion

- Ms. T sees Dr. U, and requests insertion of a copper intrauterine contraceptive
- Ms. T weighs 220 lbs and has a BMI of 40.2
- Dr. U inserts an IUD with some difficulty due to Ms. T's body habitus
- How should Dr. U code for this visit?



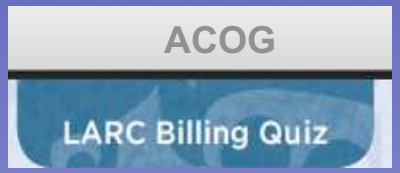
Case Study 3: Answer

	CPT code	ICD-10-CM code
Procedure	58300 (IUD insertion)	Z30.430 (insertion of IUD) Z68.41 (BMI of 40-44.9)
Supply	Check with payer for IUC insertion	
Drug	J7300 (copper IUC)	Z30.430
Lab	None	
E/M	None	
Modifier	58300-22	

- Dr. U documents the additional work, complexity, and risk to the patient to support use of the modifier – 22
- Include med record note or explain in claim "remarks box"

Case Study 4: Discontinued IUC Insertion

- Ms. X, a new patient, requests insertion of an IUD
- After consent, Dr. Y attempts to insert a copper IUD
- Dr. Y tries to insert the IUC several times, but the patient has a stenotic cervical os and having pain. Dr. Y desists
- Dr. Y discusses other methods of contraception with Ms. X and she decides to try OCs
- This conversation lasts 20 minutes. The total time of the office visit was 35 minutes



Modifier-52 vs. Modifier-53
Failed or Discontinued Procedures

- Modifier-52 (reduced services): procedure is started but can't be finished for technical reasons
  - Essure procedure: 1 coil successfully placed in one tube but the second could not be placed EMB attempted but not completed 2º to stenosis
- Modifier -53 (discontinued procedure) owing to concerns regarding patient toleration of the procedure
  - Vaso-vagal episode during sounding
  - Perforation during IUD insertion

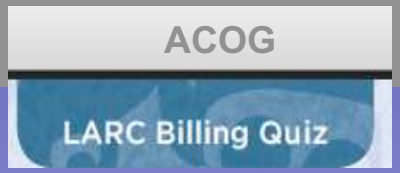
Case Study 4: Answer

	CPT code	ICD-10-CM code
Procedure	58300 IUC insertion	Z30.430 (IUD Insertion)
Supply or Drug	J7300 (intrauterine copper contraceptive)	Z30.430 (IUD Insertion)
Lab	None	
E/M	99203-25 (new patient office visit) for counseling	Z30.09 Encounter for other general counseling and advice on contraception
Modifier	58300-53	

- **Modifier -53 indicates that the procedure was attempted but discontinued because of pain**

Case 5: Post-SAB IUC Insertion

- Ms. N is 10 weeks pregnant and sees Dr. O because of vaginal bleeding
- She had seen Dr. O previously for obstetric care
- Dr. O performs an exam, asks questions, and performs a limited ultrasound
- She decides Ms. O is having a miscarriage and suggests immediate treatment
- Ms. N also requests insertion of a copper IUD
- Dr. O completes the miscarriage surgically and inserts an IUD during this visit



Case Study 5: Answer

	CPT code	ICD-10-CM code
Procedure	59812 (incomplete abortion completed surgically)	O03.39 (Incomplete spontaneous abortion with other complications)
	58300-51 (IUD insert)	Z30.430 (insertion of IUD)
	76817 (transvag UTZ)	O03.39
Drug	J7300 (copper IUD)	Z30.430
Supplies	Check with payer	
Lab	Rh type	
E/M	None	
Modifier	None	

Advanced Cases

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