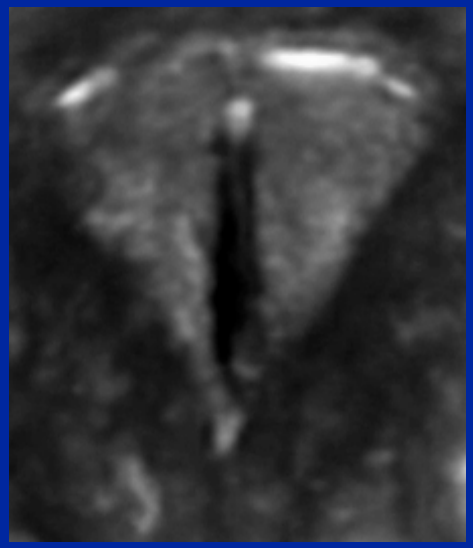


Taking Your IUD Skills to the Next Level

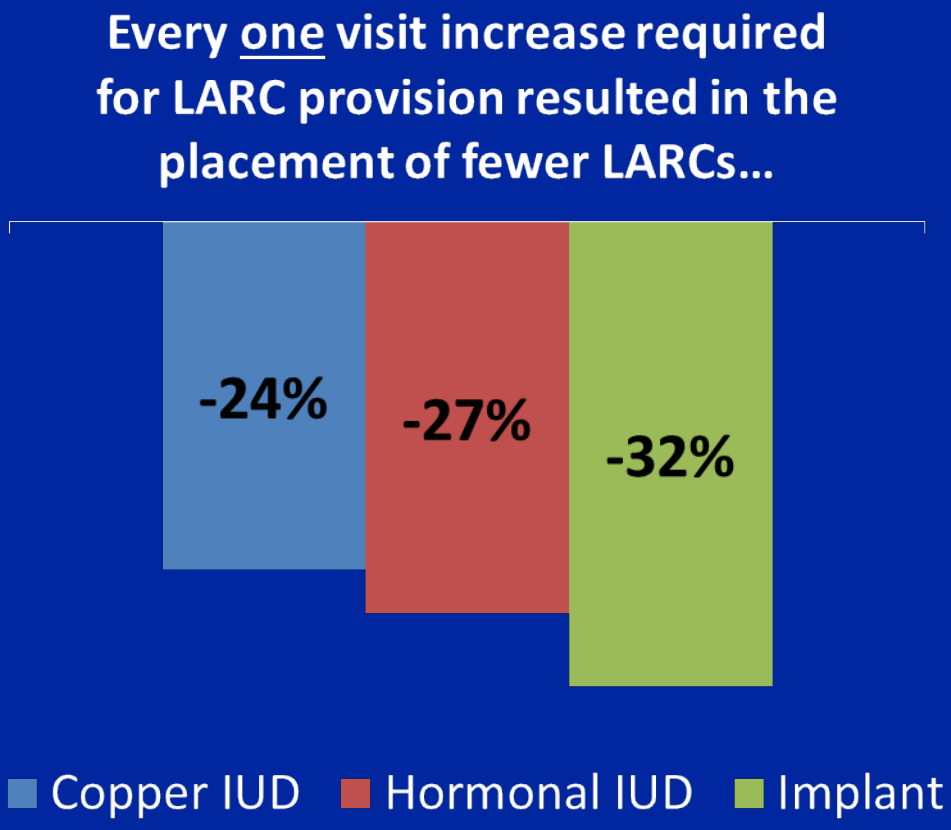
Patty Cason, MS, FNP-BC
Envision SRH
UCLA School of Nursing
Arthur Ashe Student Health and Wellness Center
envisionsrh.com

Michael Policar, MD, MPH
Professor Emeritus of Ob, Gyn, RS
UCSF School of Medicine
michael.policar@ucsf.edu

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"
  - Refuted by CDC MEC and SPR

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
    - Emergency contraception visit
    - Other concerns or complaints

1 hour Online LARC Training

http://beyondthepill.ucsf.edu/online-training

- CME available
- Free
- Self Paced
- Interactive
- For all staff

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

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 and repeat abortion *by two-thirds*

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: 3-5%
    - 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

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)	4 (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?

Questions to Ask after Giving Information

- 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

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 y.o. G_1P_1

"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 y.o. G_1P_1

“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!”

Kristal 22 y.o. G_2P_1

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

"Your mother is completely right!.... when you are not on hormonal contraceptives, it is important to get a monthly period. 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 y.o. G_2P_1

"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)

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

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.”

Informed Consent

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

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

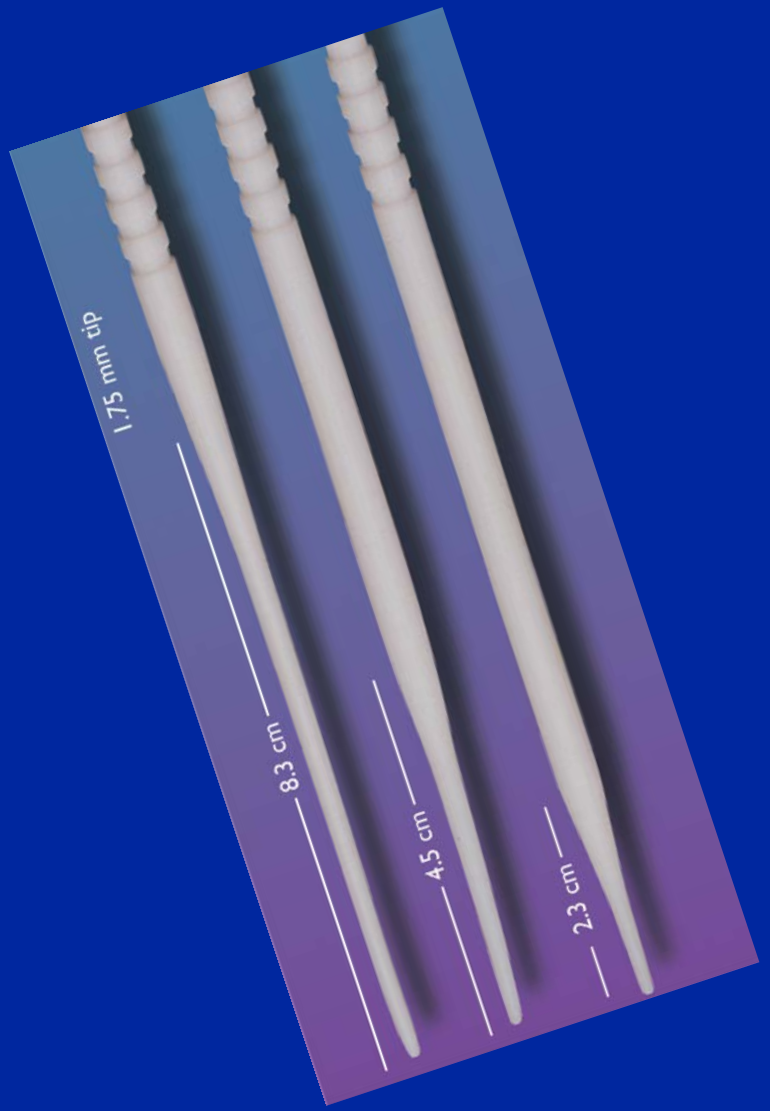
3. Gently hold the sound at the internal os and then wait --to allow the os to yield
4. Change the curvature of the sound (if metal)
5. Apply light pressure at various angles 360^{o} and positions with the sound looking for an opening
6. Approach more anteriorly or posteriorly

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 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 the (small) sound in the canal and come alongside the sound with the inserter

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 if sounding difficult

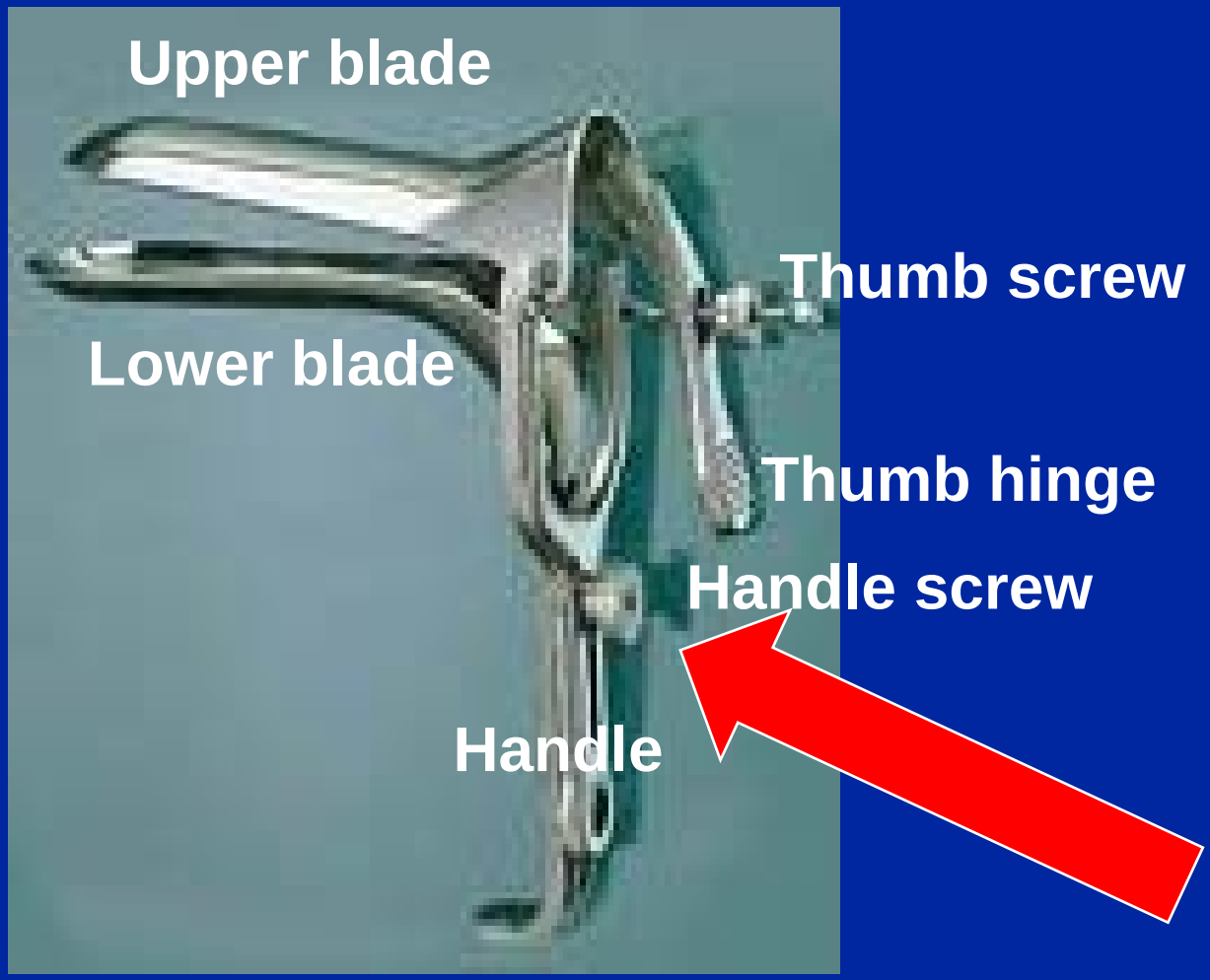
Obesity: Have Appropriate Instruments in the Room

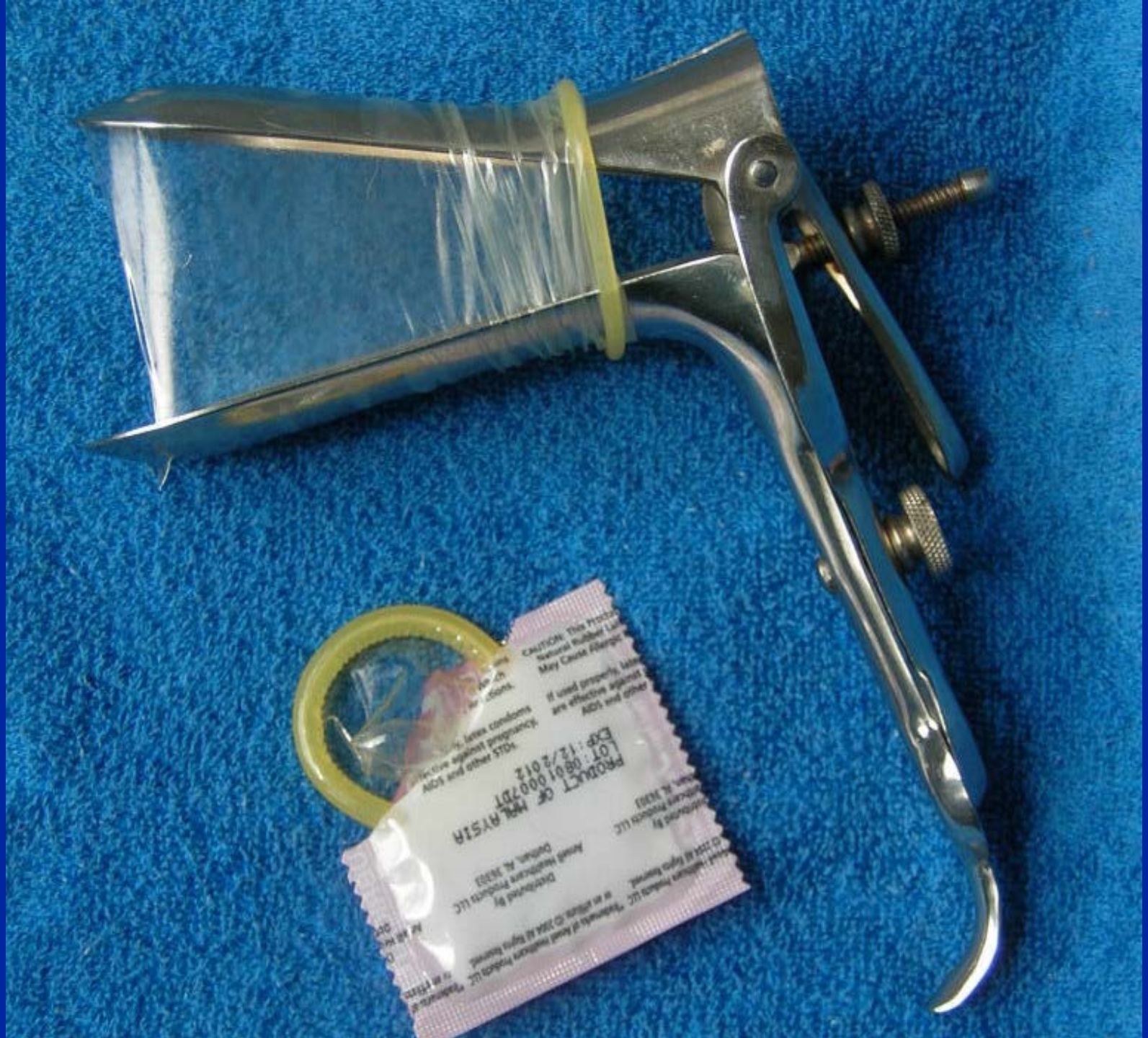
- Specula of varying sizes
- Ensure adequate lighting
- Tongue blades or retractors or ring forceps
  - Use closed ring forceps or tongue blade to gently push vaginal walls to the side to improve visibility

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

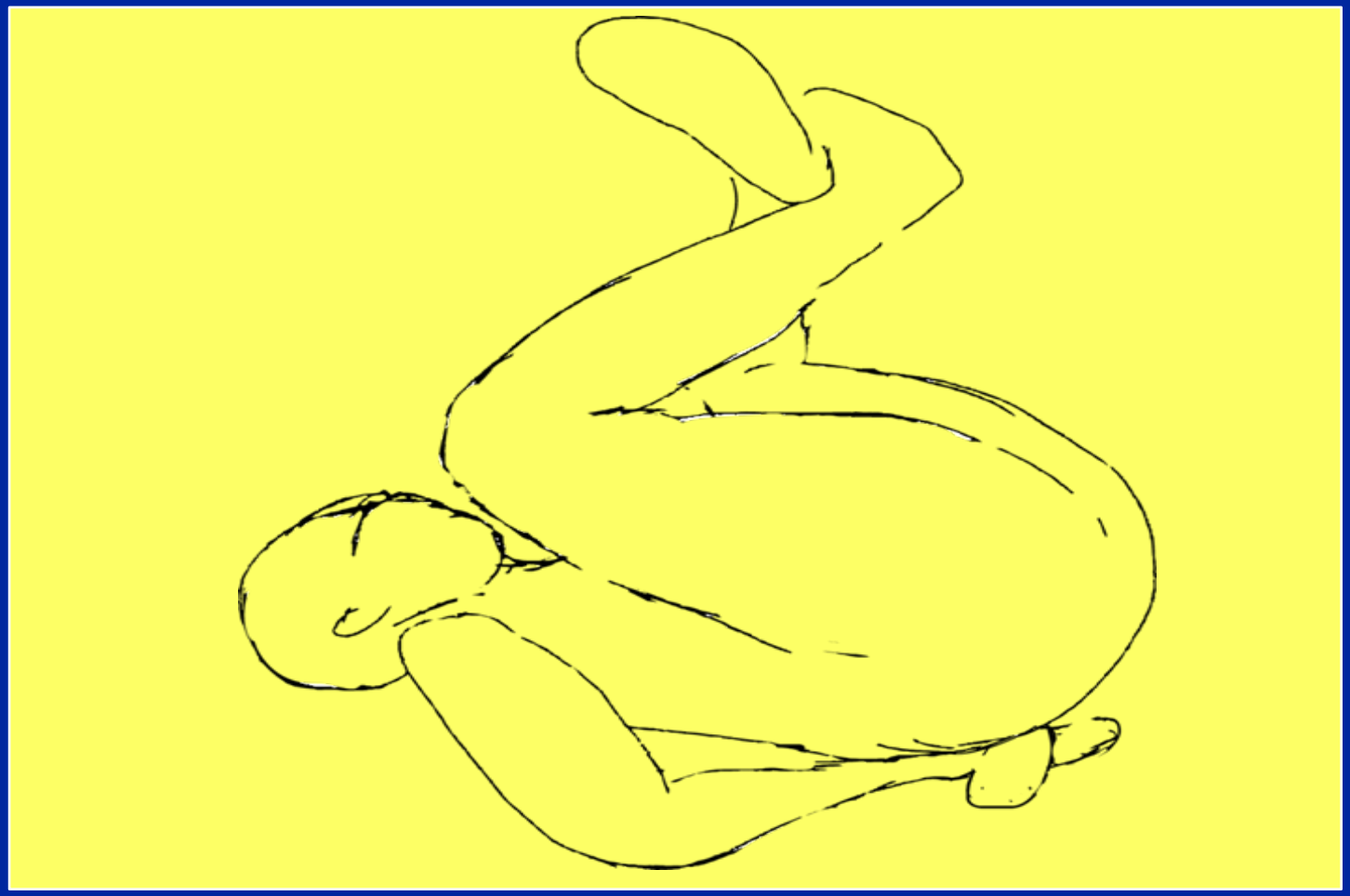
- Hips over the edge of the exam table drops her pelvis and cervix forward and makes visualization easier

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

Insertion Tips: Women with Fibroids

- Determine fibroid location by ultrasound
  - Fundal fibroids (intramural, sub-serous) that do not distort uterine cavity do not preclude IUD use
  - Large sub-mucous fibroids, especially in lower uterine segment, contraindicate IUD use
  - Evaluate for other pathology, e.g., polyp
- Ultrasound guidance may facilitate safe placement
- No data on efficacy, but probably not compromised with LNg-IUS or with copper IUD if fundal placement

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 **ASK**
  - Breathing techniques
  - Mindful mediation
  - Guided imagery

Distraction

Non-Steroidal Anti-inflammatory Drugs

Cochrane review, 2015

- Tramadol and naproxen had some effect on reducing IUD placement 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-placement cramping

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

Oral Sedation

- Not routinely; reserve for special cases
- Obtain informed consent *before* meds given
- Options
  - Benzodiazepine eg. alprazolam, diazepam
    - PLUS
  - Acetominophen 300 mg + codeine or hydrocodone
- Take 30 minutes before
- Develop a protocol for your office or clinic
- Needs to have a driver or an escort

What has your experience been?

Carrie Cwiak, MD, MPH

Tenaculum Pain Reduction

- Close the tenaculum very, very slowly
- Close the ratchet *silently*
- Close only to the first ratchet stop
- Take a bite no larger than you need
- Explain that she may experience “a cramp”
  - Avoid using “a pinch” or “pain”

Tenaculum Pain Reduction

- Some providers recommend injection of 1cc local anesthetic at the tenaculum site
- Have patient cough or use other distraction
- Don’t move the tenaculum inadvertently
- During sounding and IUD placement, don’t hook your fingers through the rings

Uterine Sound Pain Reduction

- If difficulty sounding, consider EMB sampler
- Touch the fundus once
  - Repeated tapping is unnecessarily uncomfortable for the patient
- Move slowly and intentionally
  - Moving too quickly increases discomfort

Uterine Sound Pain Reduction

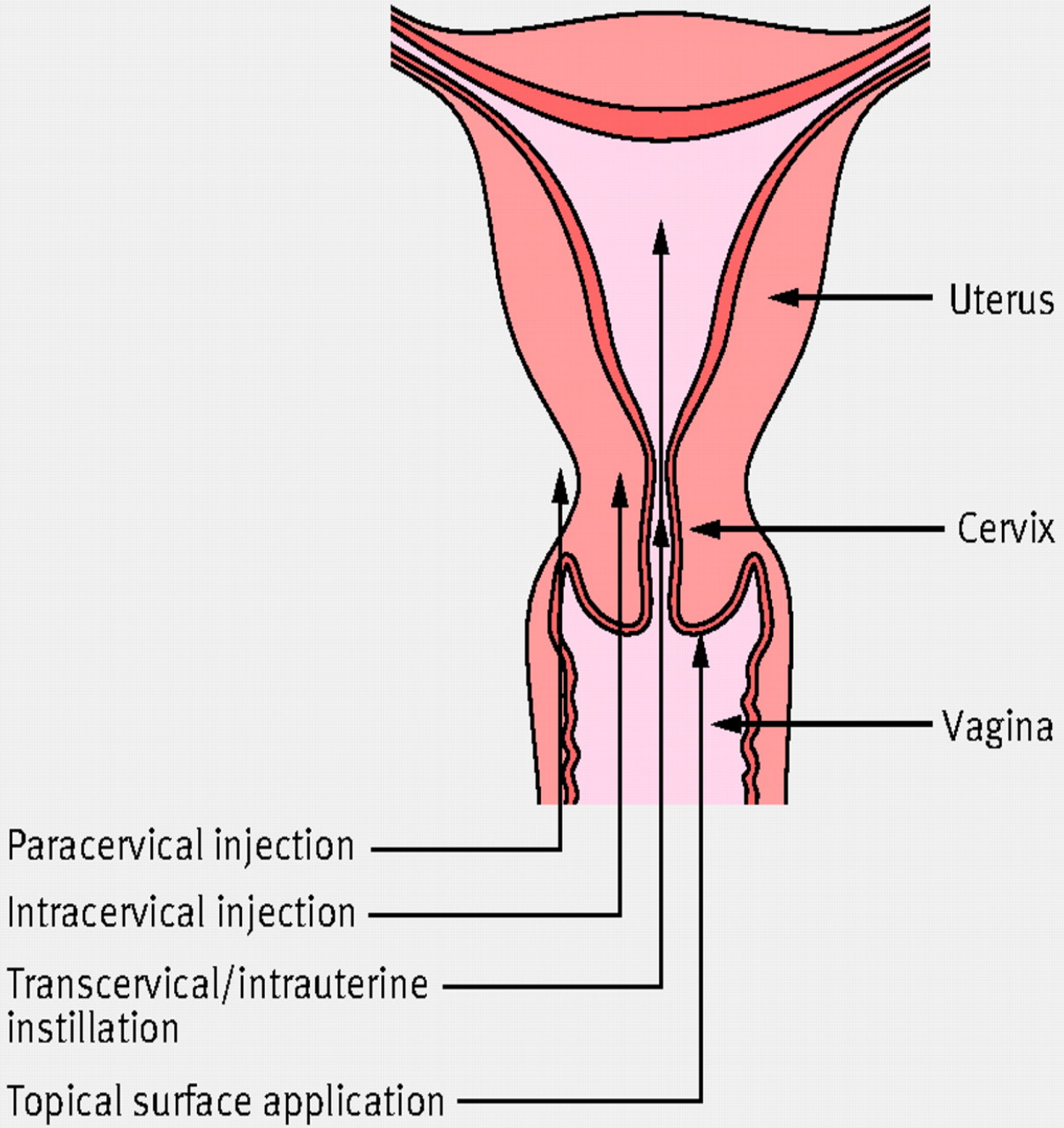
- If metal; bend sound to mimic uterine flexion
- Hold it like a pencil or dart
- Use *wrist* action
- Brace fingertips on speculum to achieve control of force while advancing the sound

Uterine Sound Pain Reduction

S-l-o-w Progression

- Through the internal os
- *Pause once when 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

- Target is uterosacral ligaments, which contain the cervical and uterine nerves
- Use spinal needle OR 25g, 1 ½" needle + extender
- Inject at reflection of cervico-vaginal epithelium
  - 5-10 cc 1% lidocaine (no epinephrine) each side
  - Submucosal injection 5mm-1cm deep
- Moore-Graves speculum allows more movement
- WAIT 1-2 minutes after placing block

BD Spinal Needle

Spinal Needle Quincke Type Point
Aguja Espinal, punta tipo Quincke
Agulha de ponta Quincke
Aiguille Spinale Biseau de Quincke
Spinalkanüle mit Quinckeschliff
Ago Spinale: Punta tipo Quincke
Spinale Naald met Quincke punt
Spinalnål med Quincke slipad spets

CE 0050

STERILE EO

Becton, Dickinson and Company, 1 Becton Drive, Franklin Lakes, NJ 07417 USA

Made in USA

REF 405181

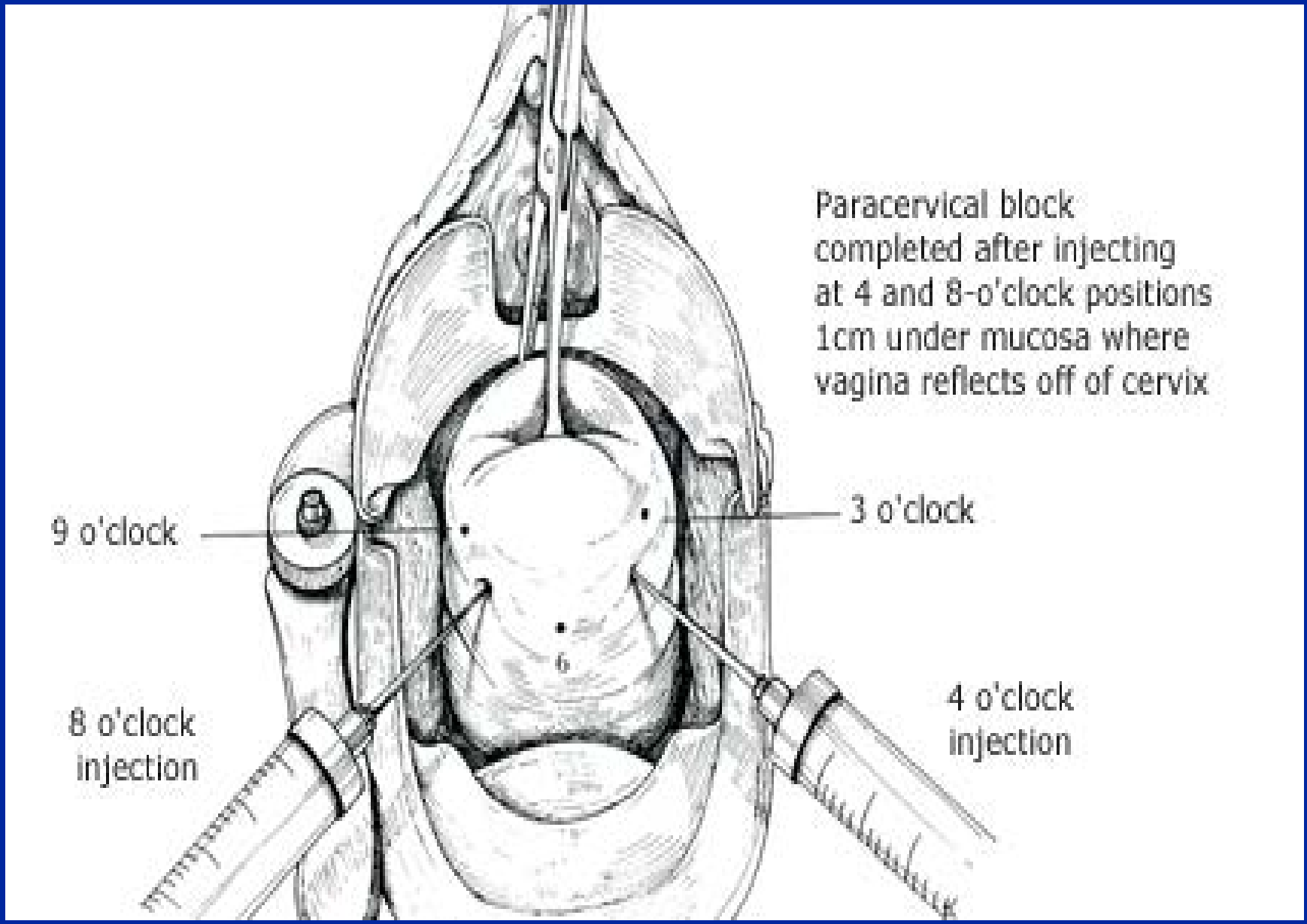
22G x 3.50IN
0.7 mm x 90 mm

(01)00382904051815

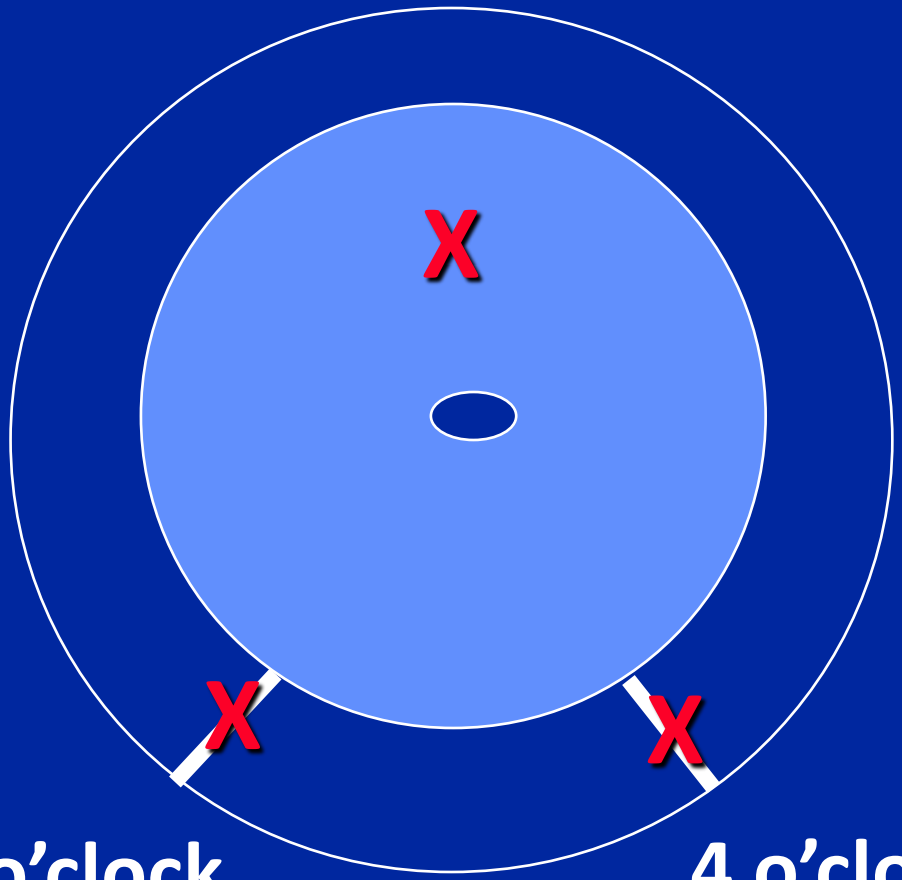
2021-10-31

LOT 6299695

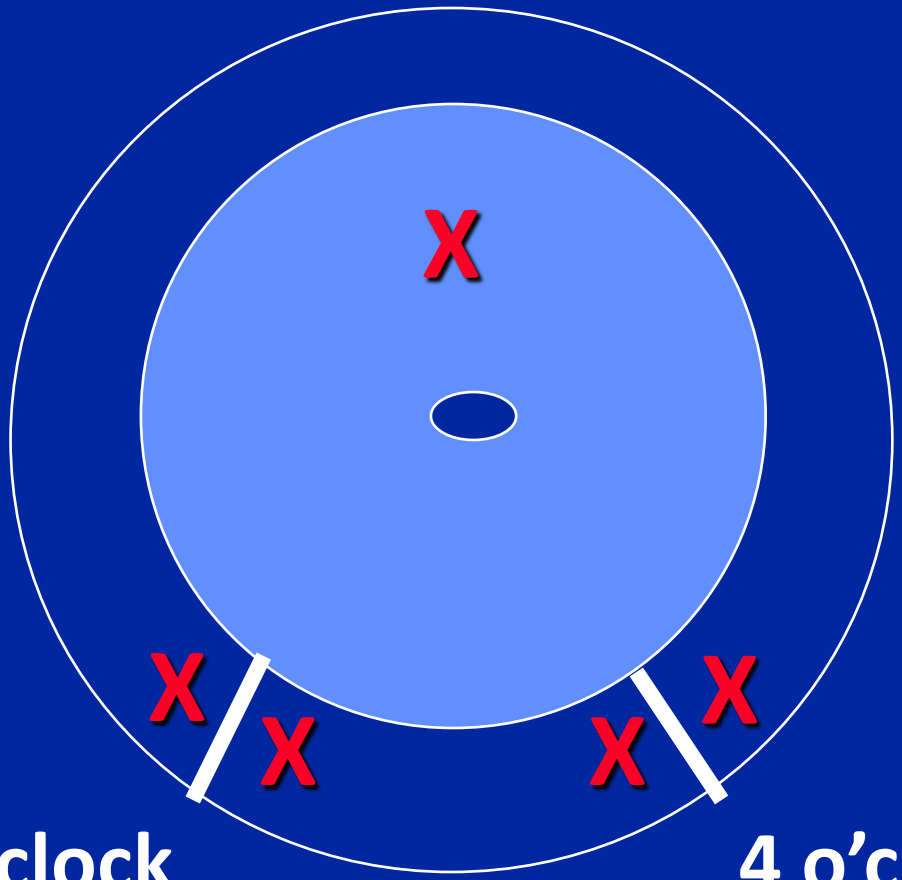
Paracervical Block



Paracervical Block



Paracervical Block

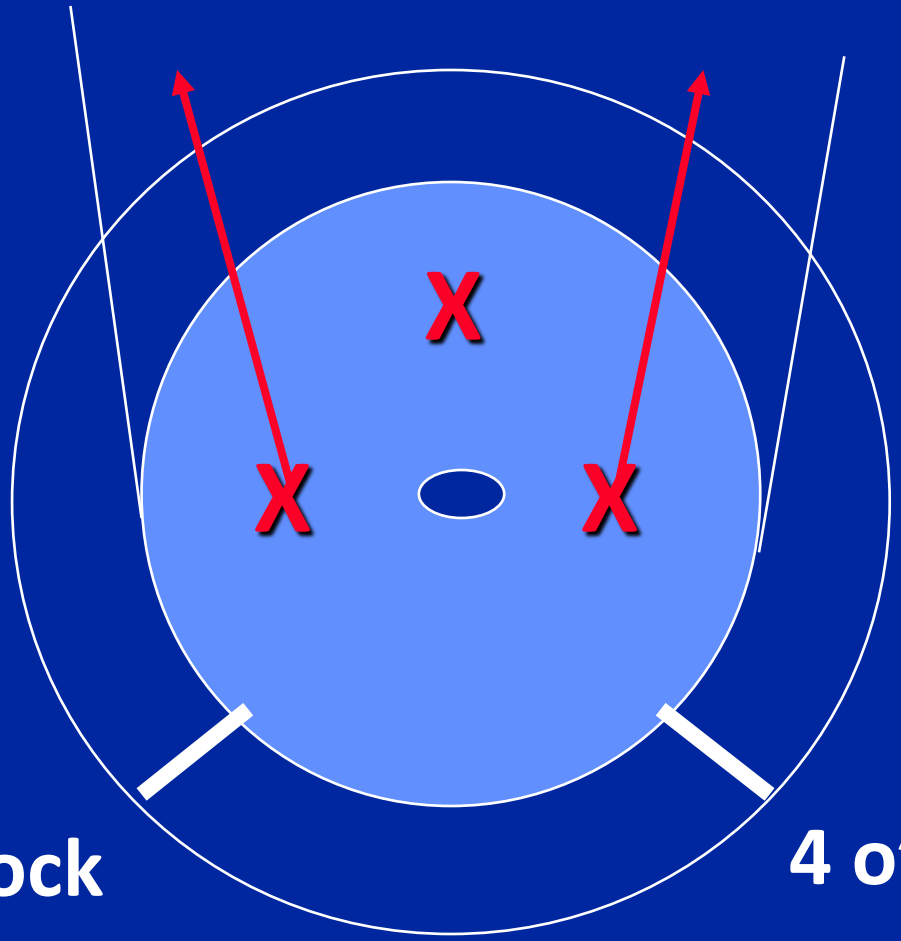


Intracervical Block

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


1
2
3
4
5
6
7
8
9
10ml

Intracervical Block



9 o'clock

3 o'clock

8 o'clock

4 o'clock

6 o'clock

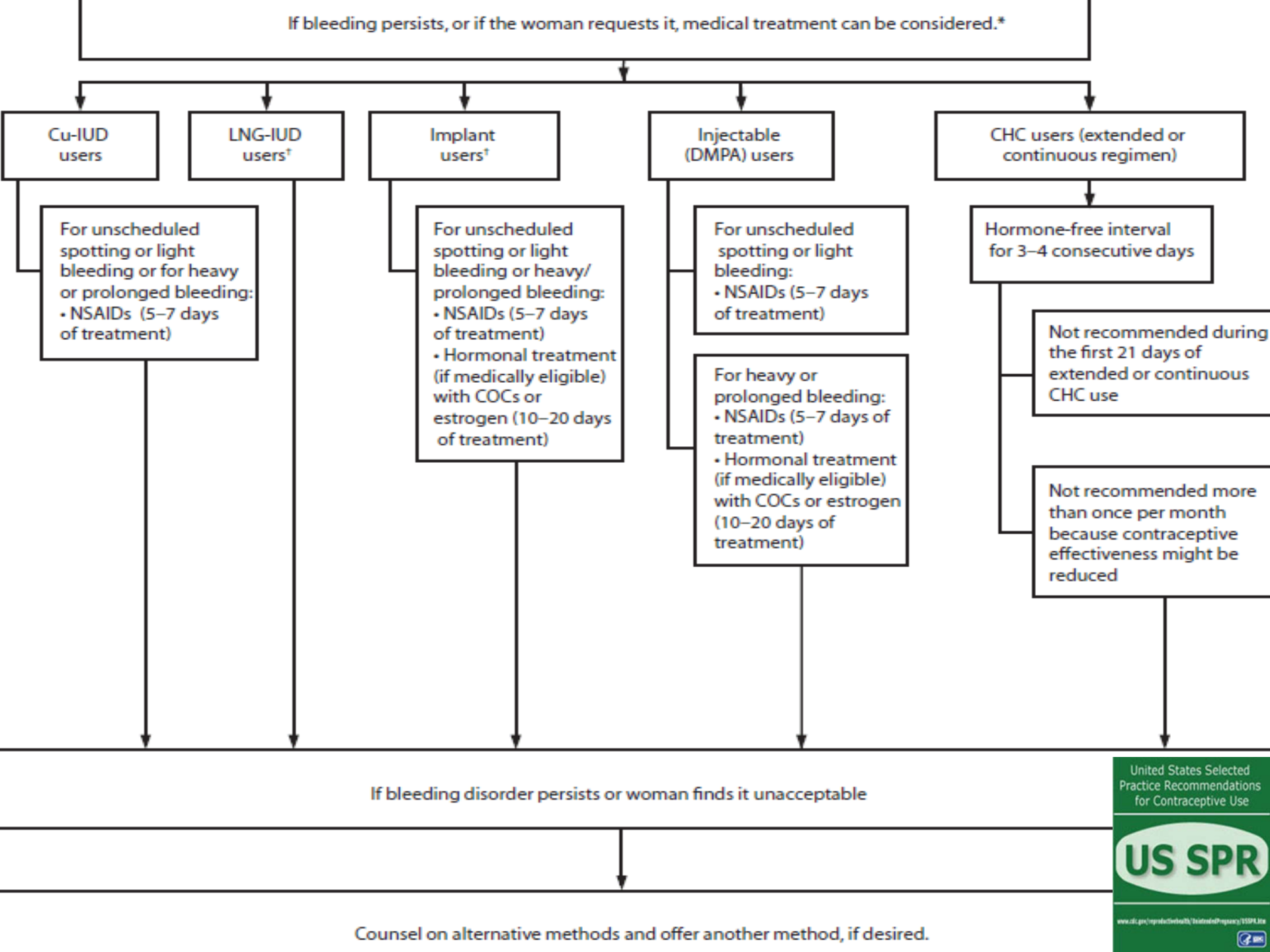
Lidocaine Safety

- Inject in correct spot
- Aspirate to avoid intravascular injection
- Metallic taste is a common side effect

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
LNG-IUD users†
Implant users†
Injectable (DMPA) users
CHC users (extended or continuous regimen)
For unscheduled spotting or light bleeding or for heavy or prolonged bleeding:
• NSAIDs (5–7 days of treatment)
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)
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)
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

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

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
  - Dehydration or NPO

Grubb BP N Engl J Med 2005

Pre-syncopal Symptoms

- Weakness
- Light-headedness
- Diaphoresis
- Visual blurring
- Headache
- Nausea
- Feeling warm or cold
- Sudden need to go to the bathroom

Presyncopal Signs

- Facial pallor (distinct green hue)
- Yawning
- Pupillary dilatation
- Nervousness

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
- This stops the reaction

Vasovagal Prevention

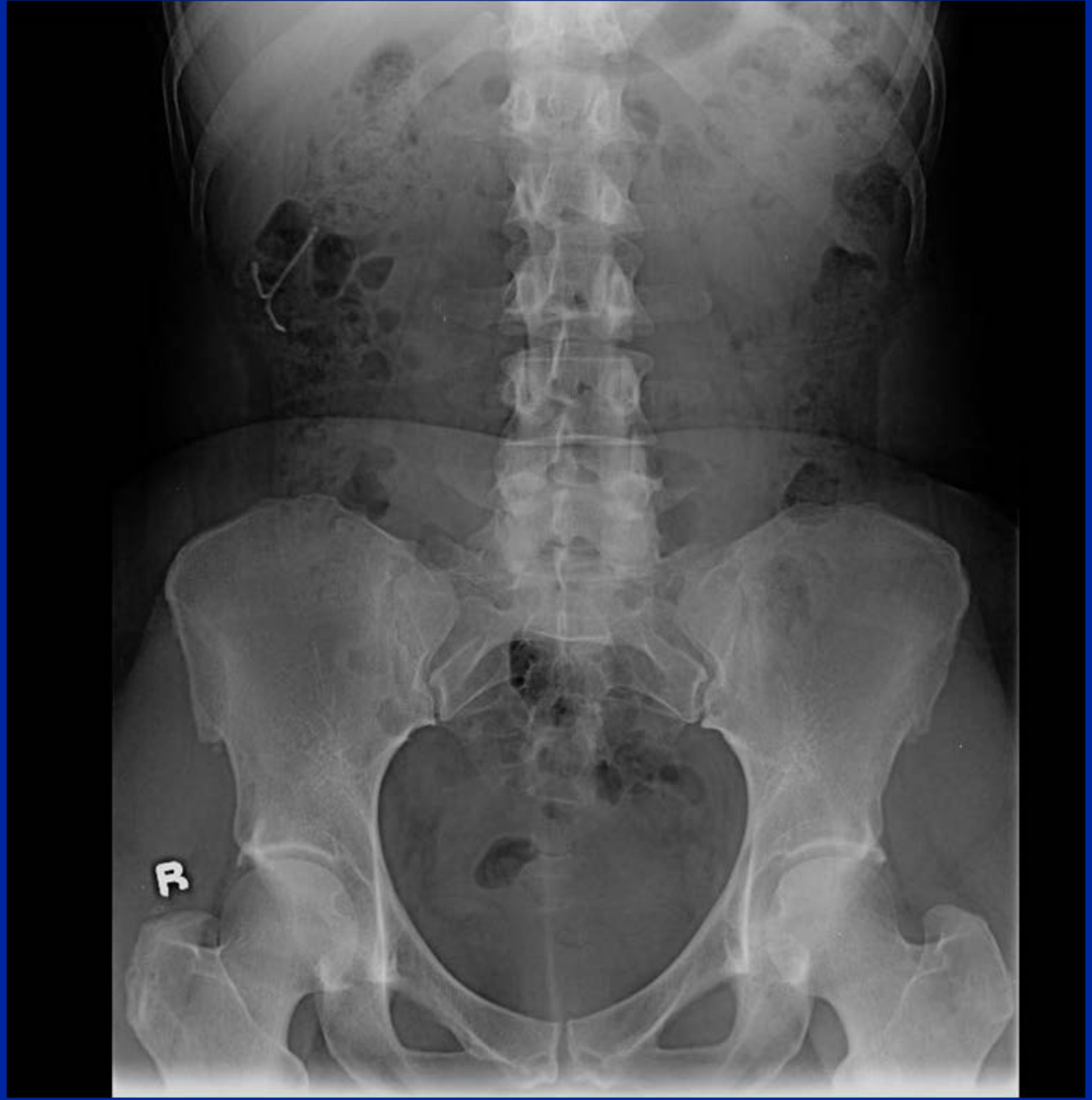
- Good hydration (electrolyte/ sports drink)
- Eat before placement
- Prophylactically contract muscles if known history

Grubb BP N Engl J Med 2005

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?


R

Uterine Perforation

- More likely to occur in relation to
  - Posterior uterine position
  - Post-partum placement, esp. in lactating women
  - Skill/experience of provider
- Usually midline at uterine fundus…if so, perforation often is asymptomatic, benign
- Suspect if sounding is much deeper than expected or if ↑ resistance followed by none at fundus
- Can be confirmed by real-time office ultrasound

Management of Uterine Perforation

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

Prevention of Uterine Perforation

- Move slowly and intentionally
- Avoid momentum, as 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 Uterine 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**

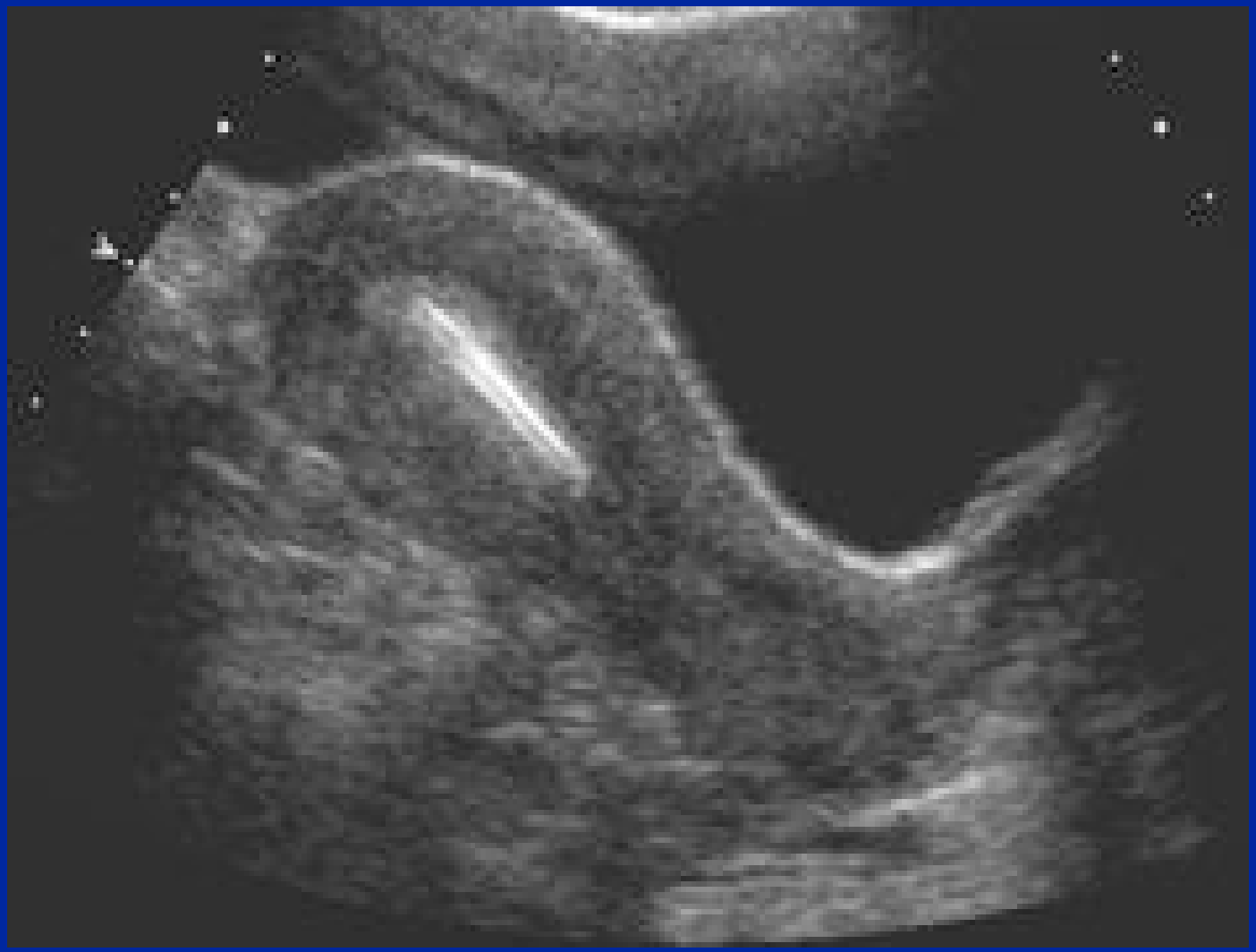
Prevention of Uterine Perforation

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

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**

Missing String: Ultrasound Guidance



Carrie Cwiak, MD, MPH

Missing String…Possibilities

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

Missing String…Possibilities

4. Malpositioning of the IUD, following perforation
   - **Translocation** into the abdomen or pelvis
   - **Embedment** into the myometrium

- 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)
- Risks of adverse pregnancy outcome are greater in the setting of IUD retention
  - Removal is recommended when strings are visible or can be removed safely from the cervical canal
  - If termination planned, the IUD can be remove at procedure to avoid triggering spontaneous abortion (SAB) or before medication abortion

Brahmi D, et.al. Pregnancy outcomes with an IUD in situ: a systematic review. Contraception 2012;85:131–9.

Missing String: Pregnancy With IUD

- If continuing IUP and strings are *not* visible, do not attempt removal
  - Counsel regarding the increased risks of SAB, septic abortion, chorioamnionitis, and preterm delivery
  - Increase surveillance during antenatal care
  - No greater risk of birth defects, since IUD is outside of the amniotic sac
  - insufficient evidence re: negative fetal effects with small exposure to LNg during gestation

Brahmi D, et.al. Contraception 2012;85:131–9.

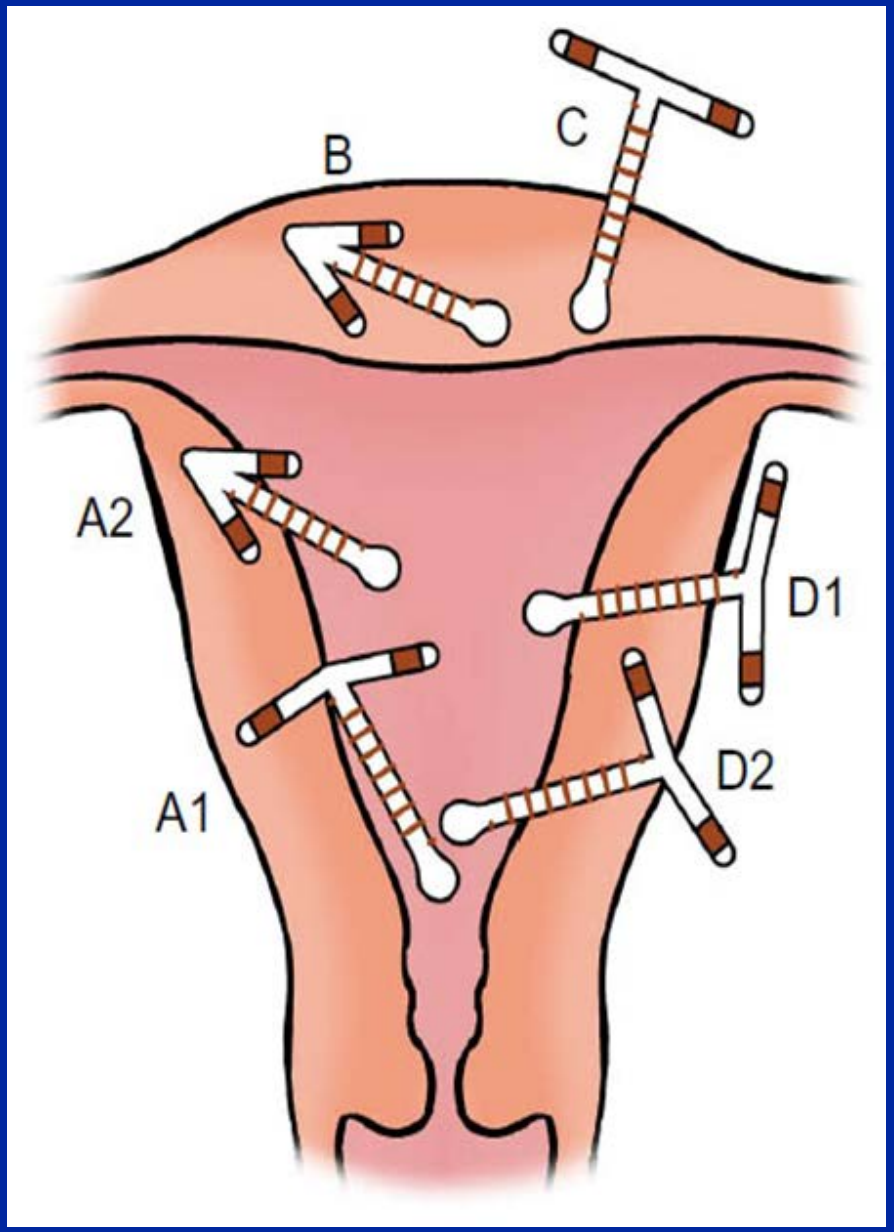
Missing String: Perforation Complication

- **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: Perforation Complication

- **Embedment**
  - Diagnosed at failed attempt at extraction or imaging
  - Remove when diagnosed, as embedment may progress to translocation
  - Advanced imaging (3-D ultrasound or pelvic CT) is critical, as it is used to direct treatment to hysteroscopy, laparoscopy, or laparotomy

Why Do CT or 3-D Ultrasound?



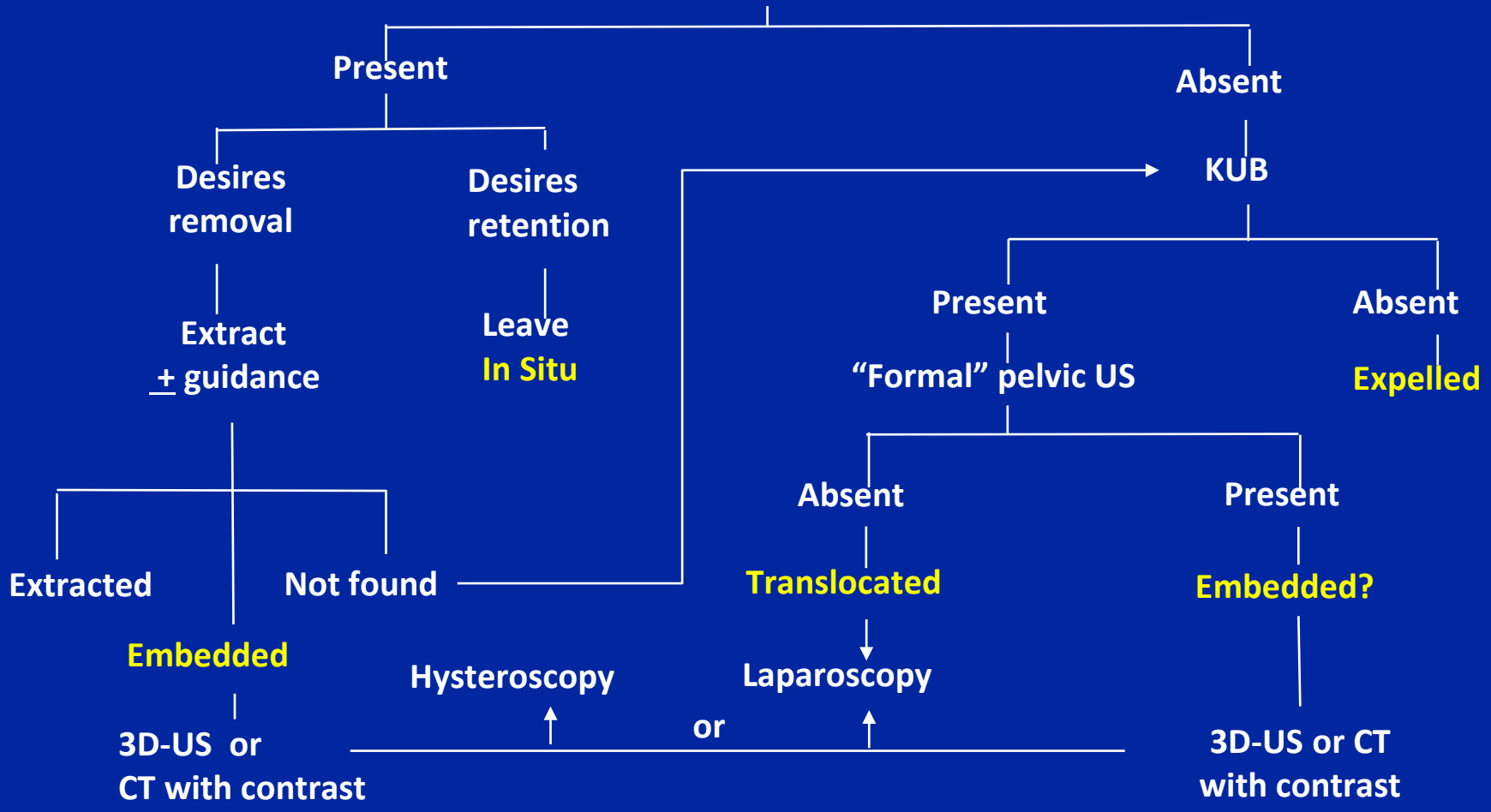
A: Hysteroscopy
B: Laparotomy
C: Laparoscopy
D_1: Laparoscopy
D_2: Hysteroscopy

Missing String: In situ Placement

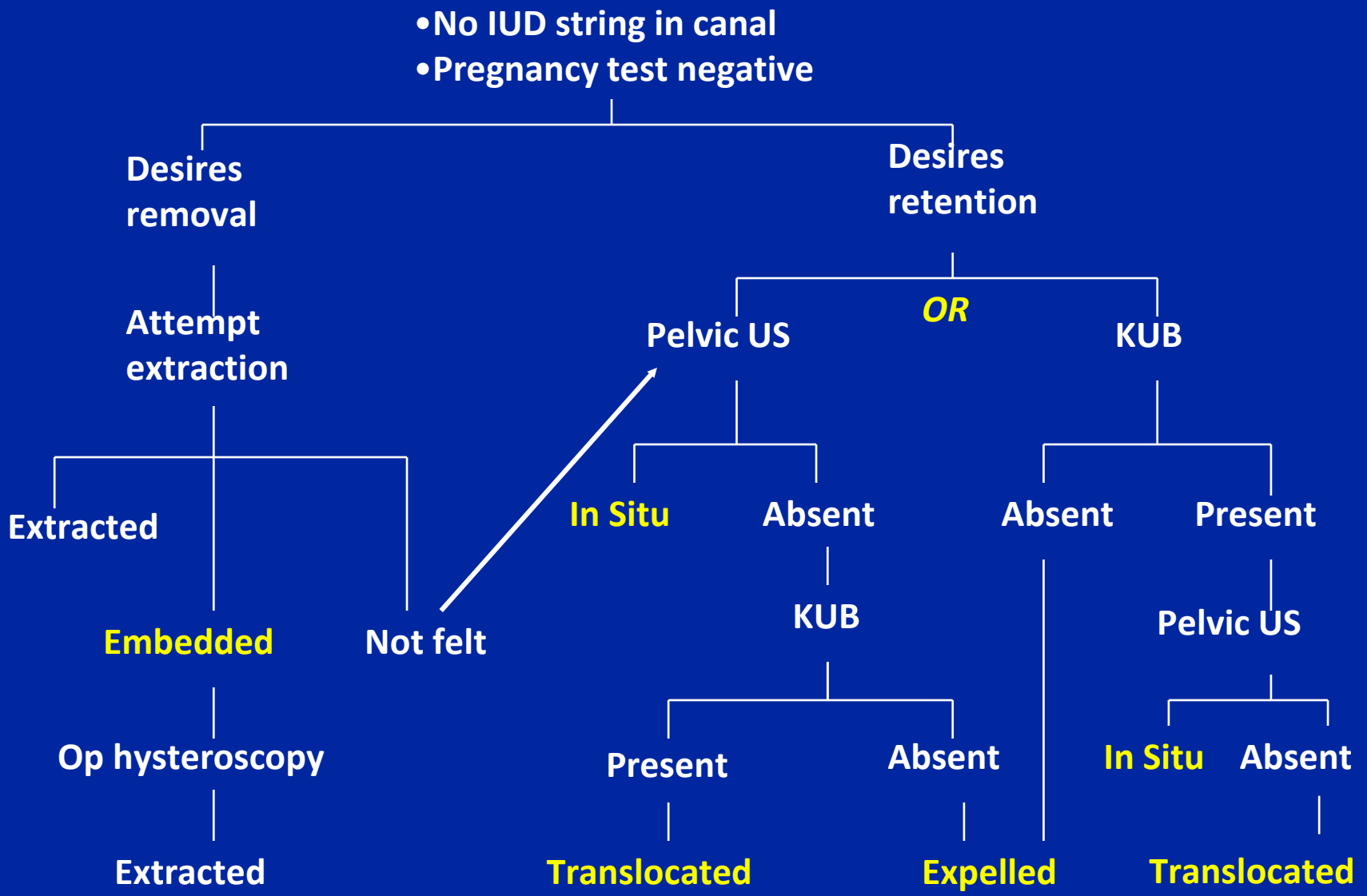
- **Desires retention**
  - Leave in place for remainder of IUD lifespan
  - Option: annual pelvic ultrasound *in lieu* of string check
- **Desires removal**
  - Attempt extraction in office

Missing String: Office Ultrasound Available

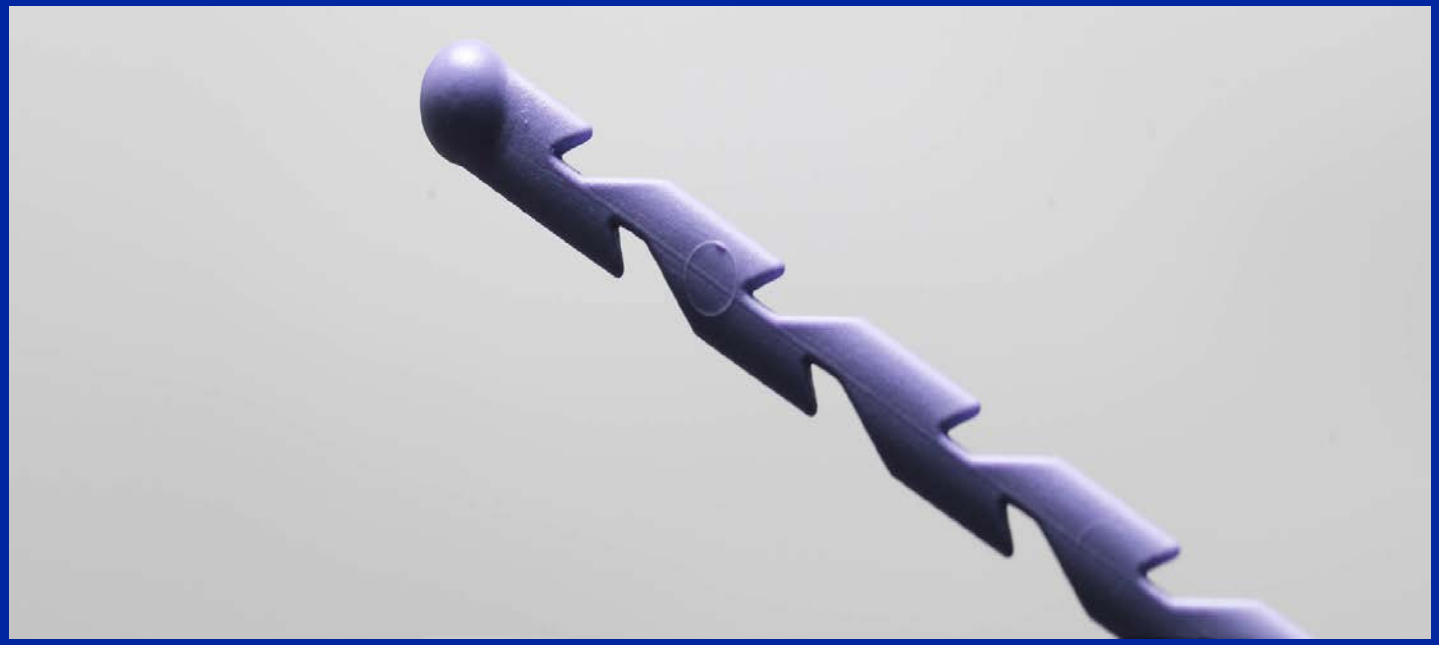
- No IUD string in canal
- Pregnancy test negative
- Office ultrasound (US)



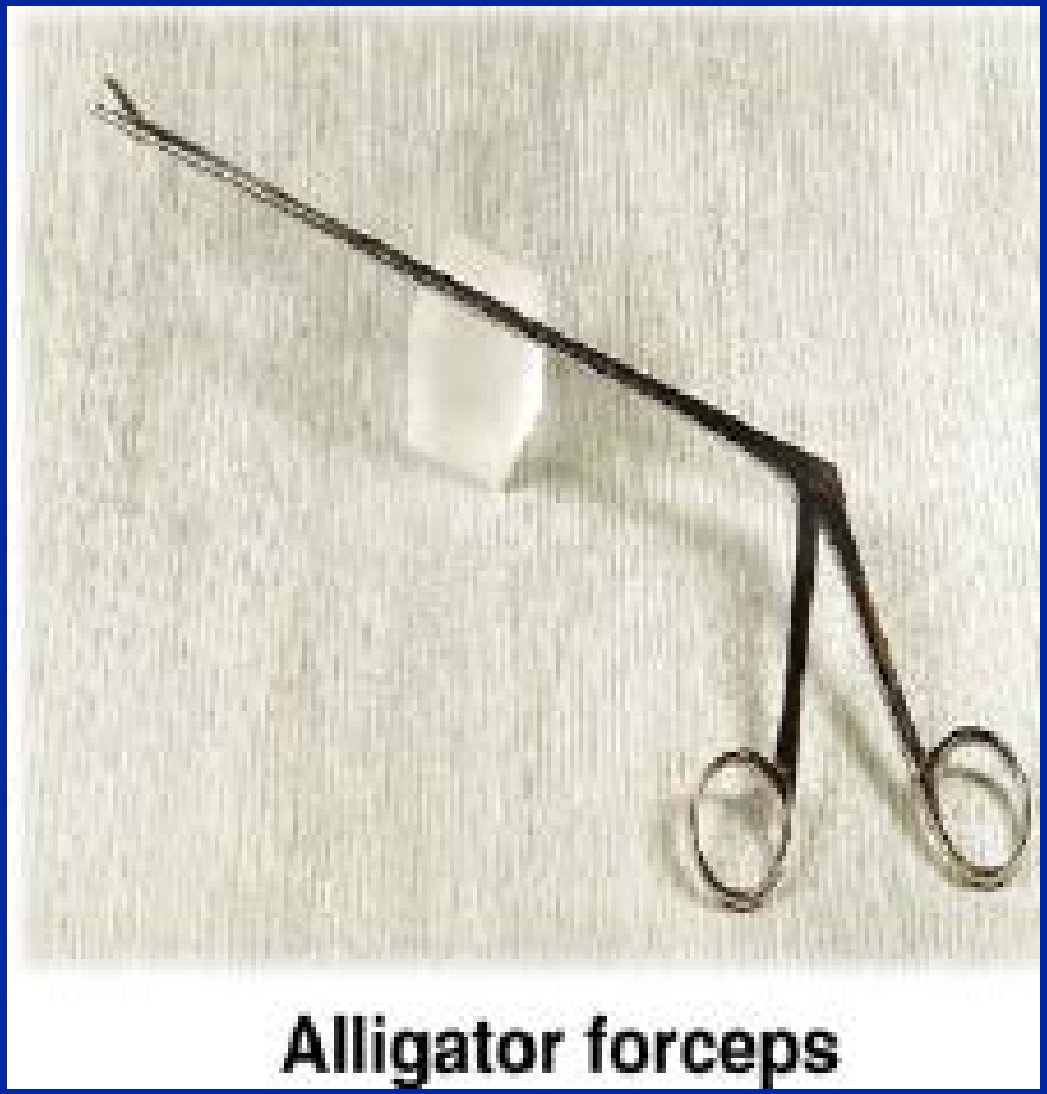
Missing String: No Office Ultrasound



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

- Intrauterine exploration for a T-shaped IUD
  - Gently open/ close ¼ turn forceps at progressive depths until "purchase" of stem or arm
  - Real-time ultrasound guidance may help
- Maneuver hook along anterior, then posterior, uterine wall from fundus to canal
- If embedment suspected, evaluate with 3-D ultrasound or pelvic CT with contrast

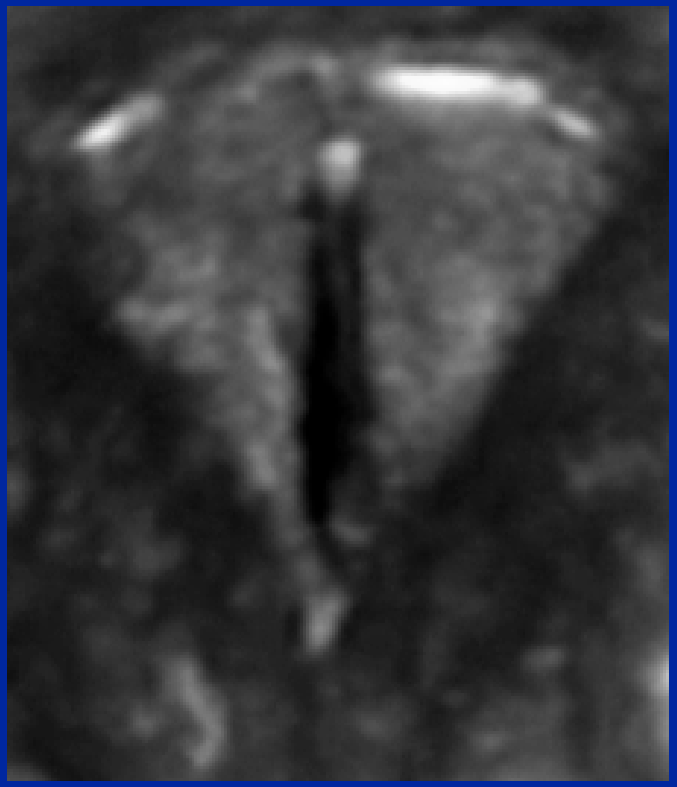
Missing String: Desires Removal

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**

IUD Removal in Menopausal Women

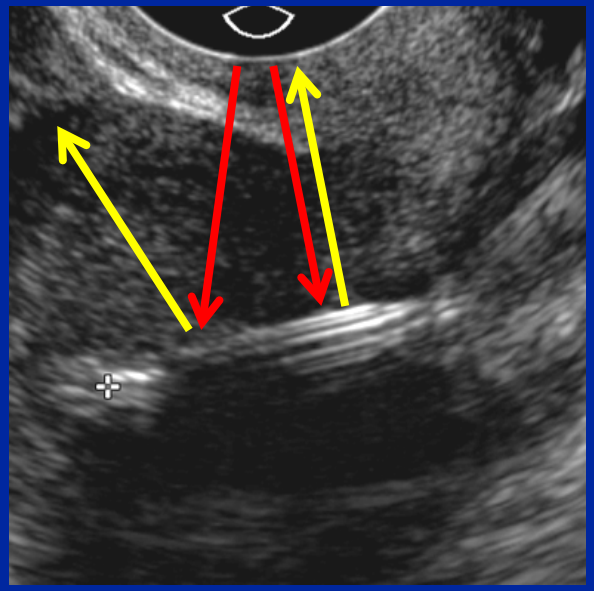
- Strings seen: remove
- No strings visible…weigh risks
  - Hazards of continuation (post-menopausal bleeding, ? pelvic actinomycosis)
  - Hazards of removal (pain, perforation)
- Tail-less IUD (e.g., Chinese stainless steel coil ring) should not be removed unless she requests it



Intrauterine Contraceptives on Ultrasound

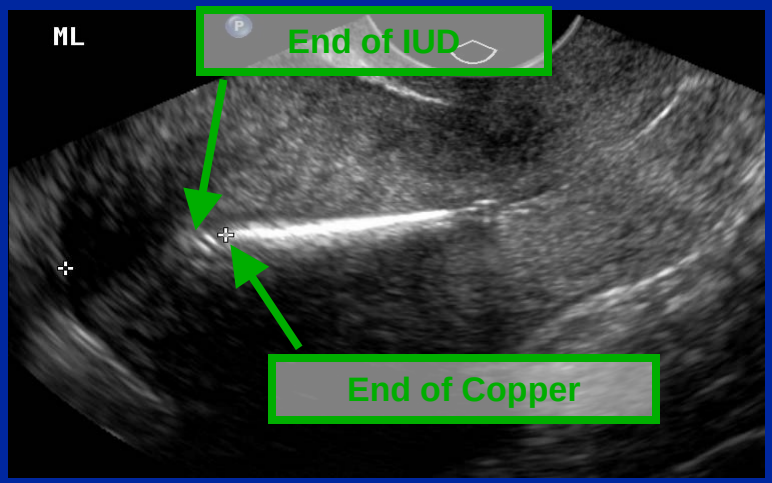
Images courtesy of Matt Reeves MD

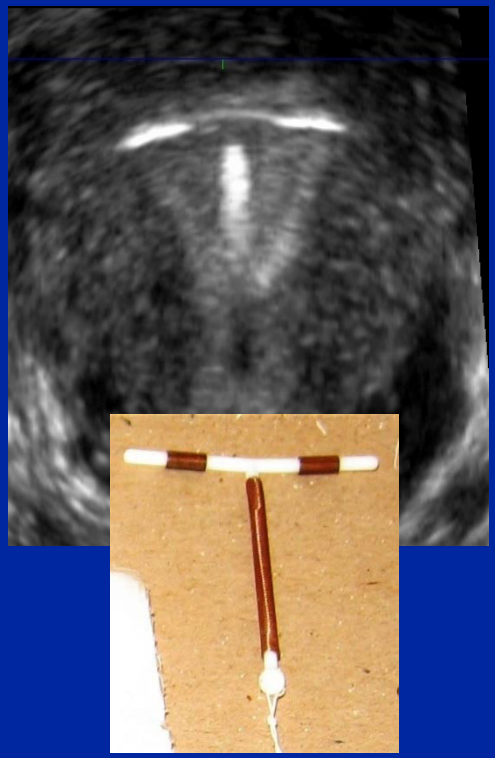
Principles of Ultrasound: How sound travels: Reflections



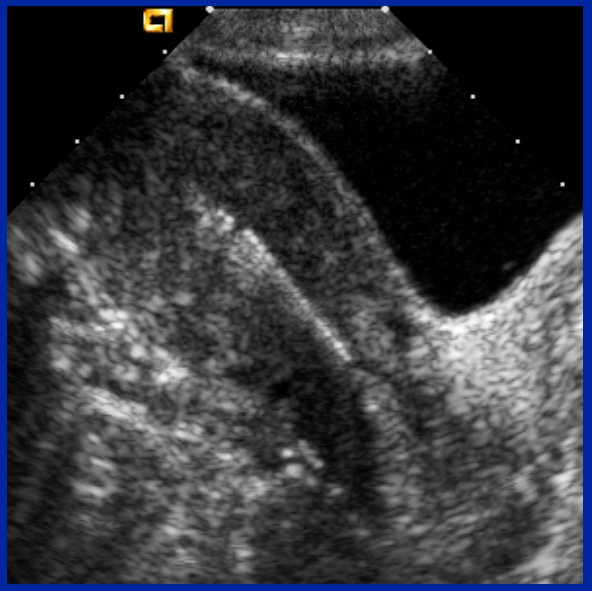
A structure at a right angle to the sounds waves will reflect more sound that the same structure at any other angle.

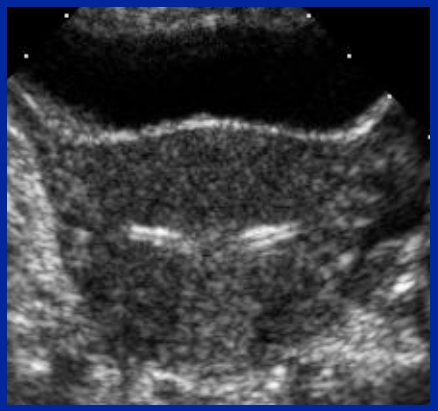
PARAGARD

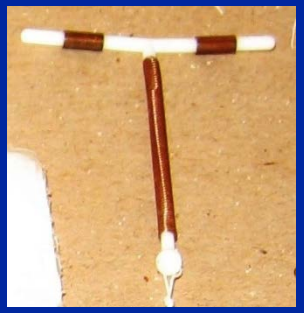




PARAGARD

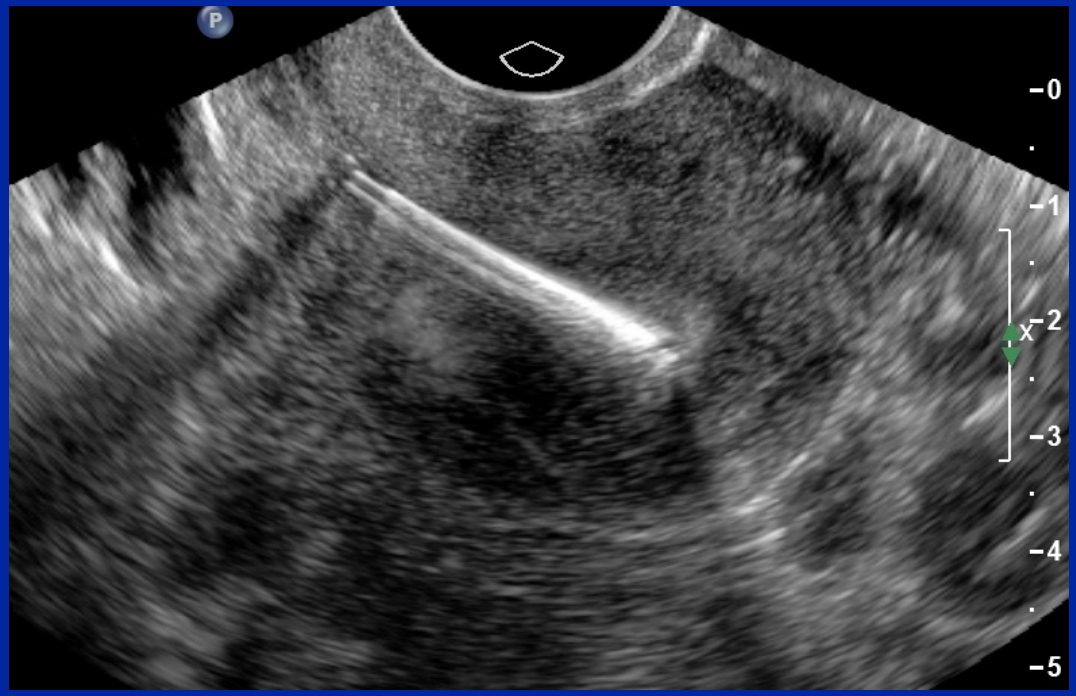




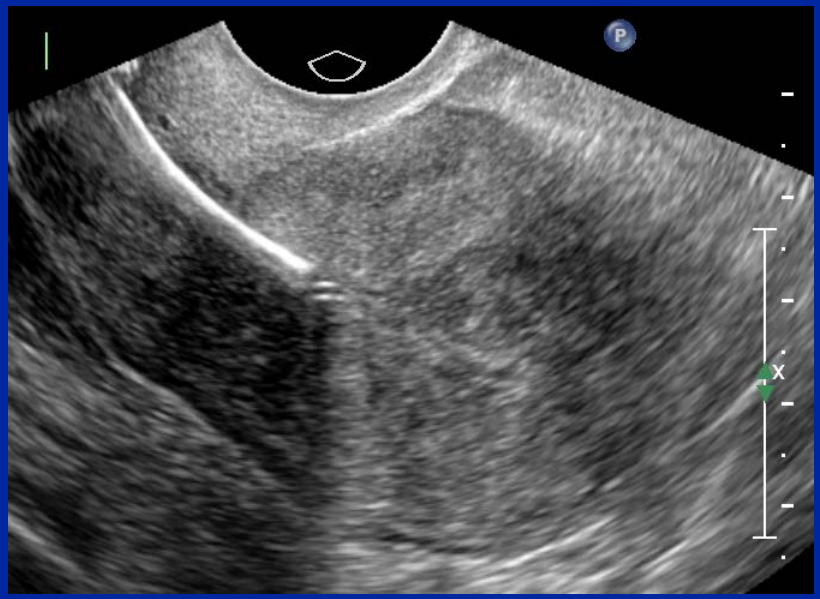


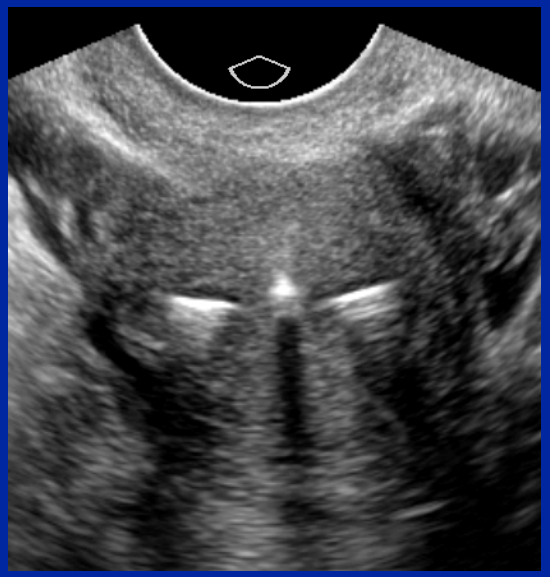
Very echogenic

PARAGARD in retroverted uterus

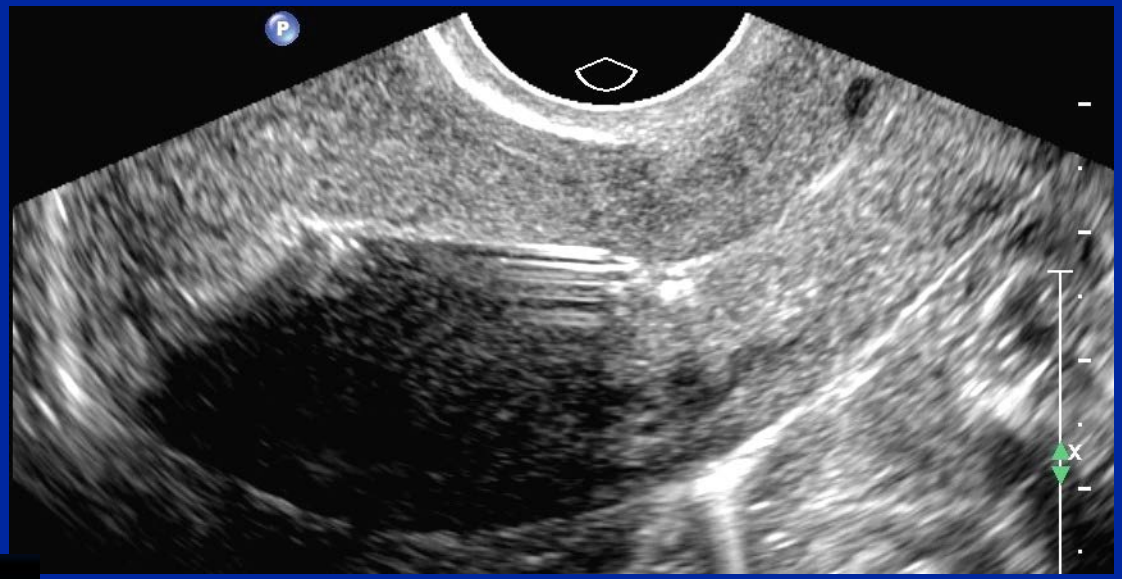


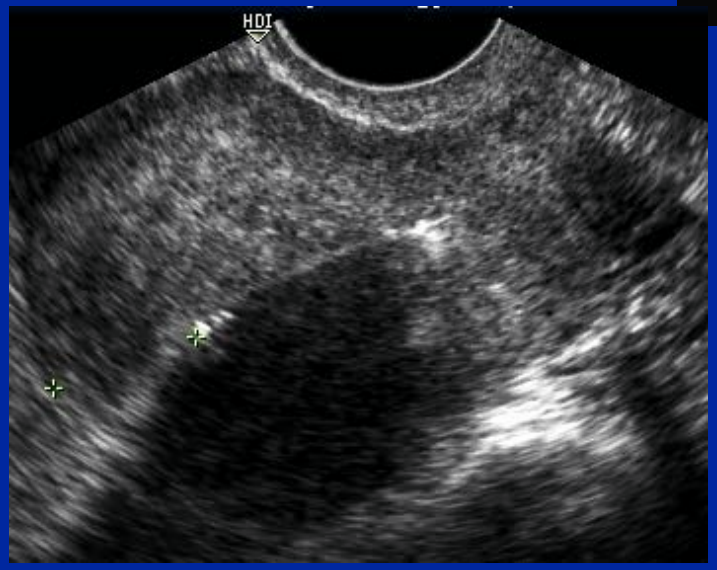
PARAGARD





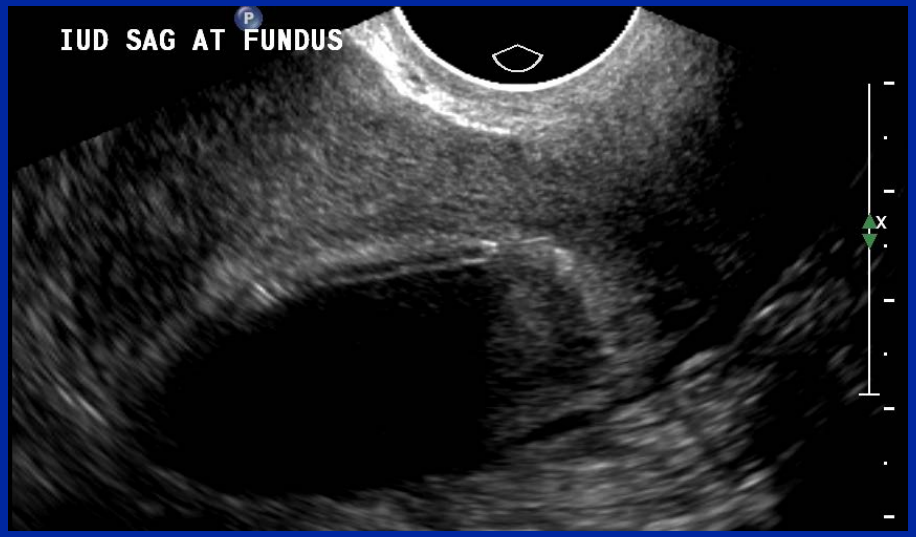
Mirena on Ultrasound

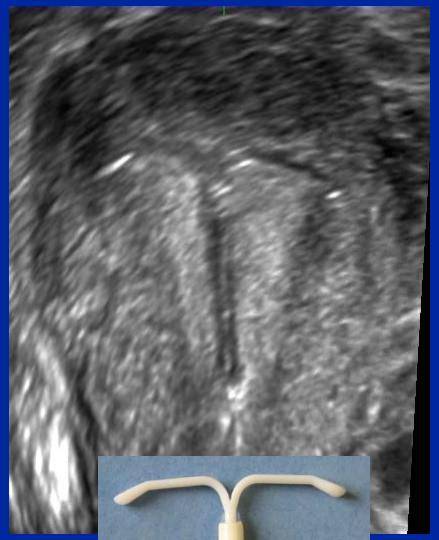




Pronounced shadowing

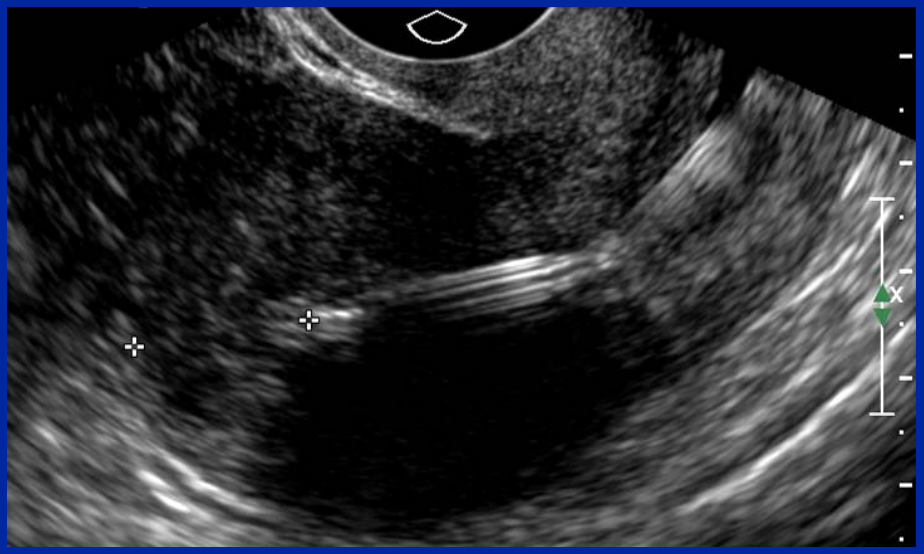
Pronounced Shadowing With Mirena





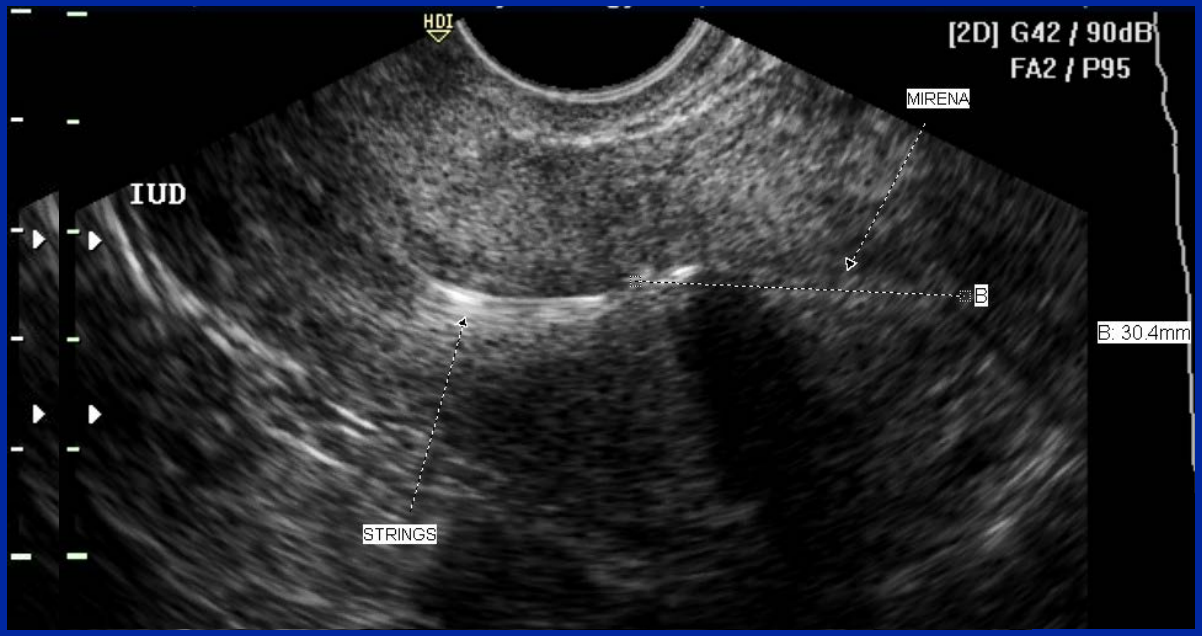
On some machines, the Mirena shadows more than others

Mirena

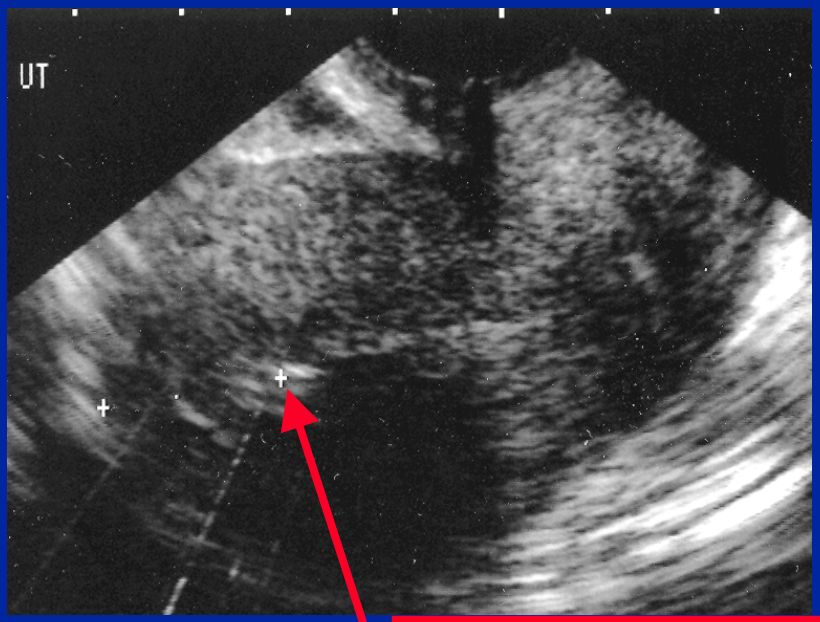


- Not very echogenic except where perpendicular to the probe
- Strings may be as echogenic as the IUD

Mirena can be Hard to Find

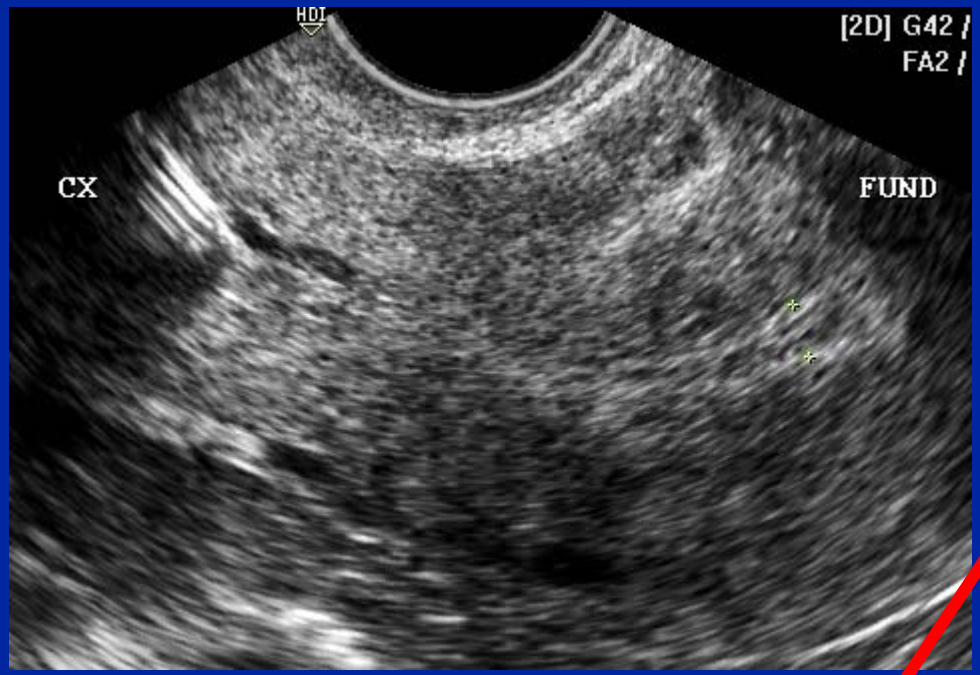


Mirena on an Older Machine



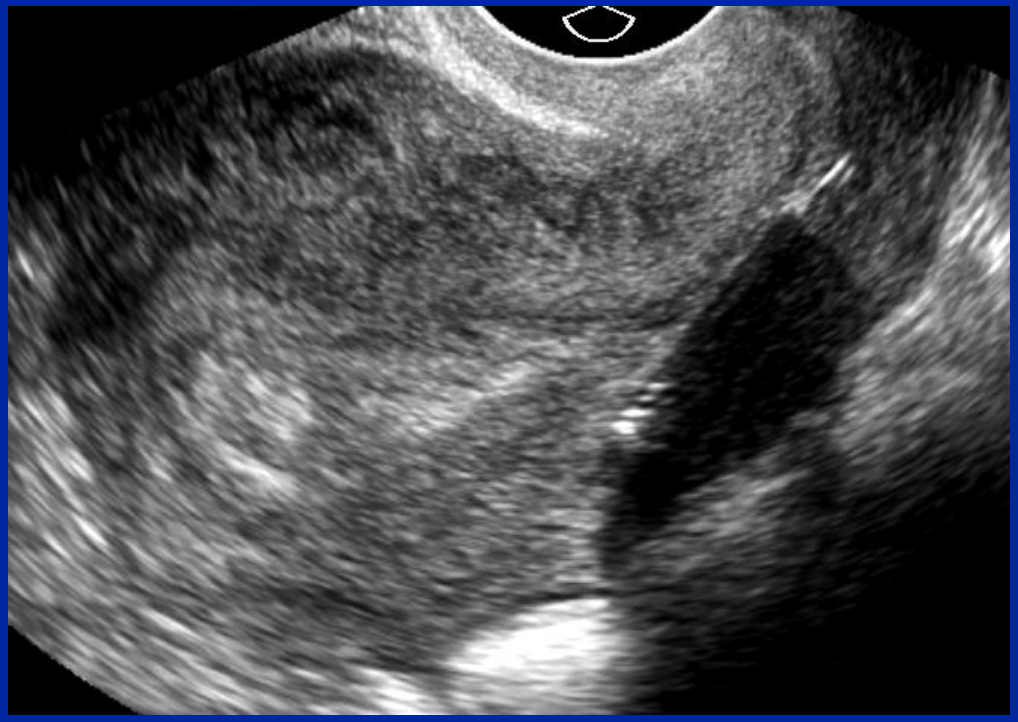
This is a scanned image from an old GE machine

Mirena in the Cervix

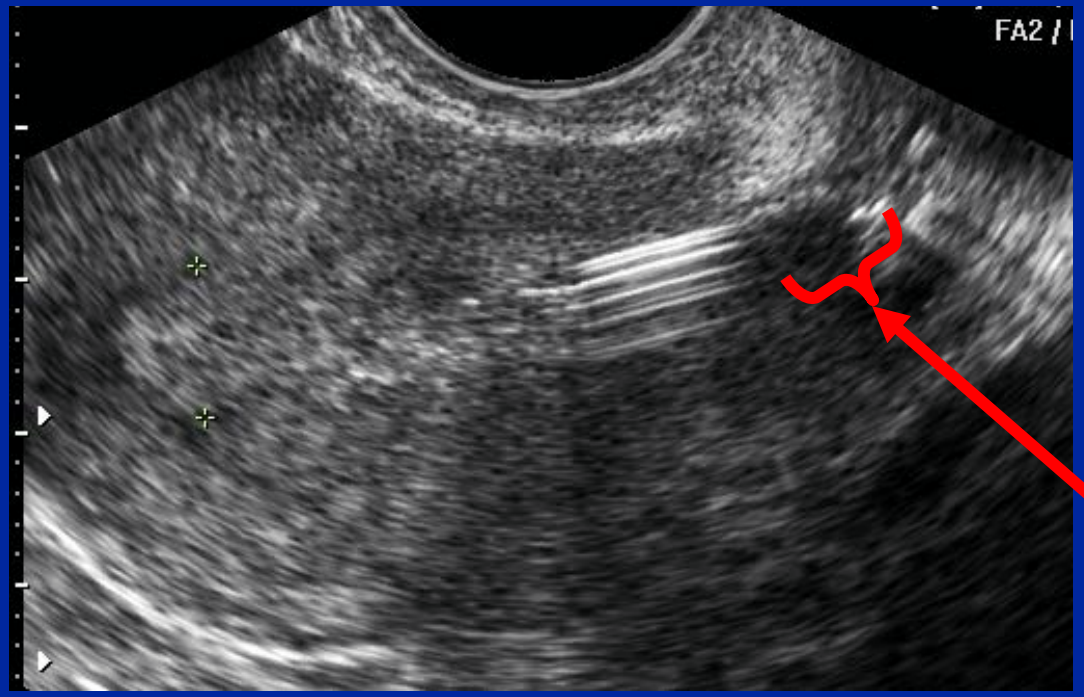


Anterior vaginal wall

Mirena in Cervix

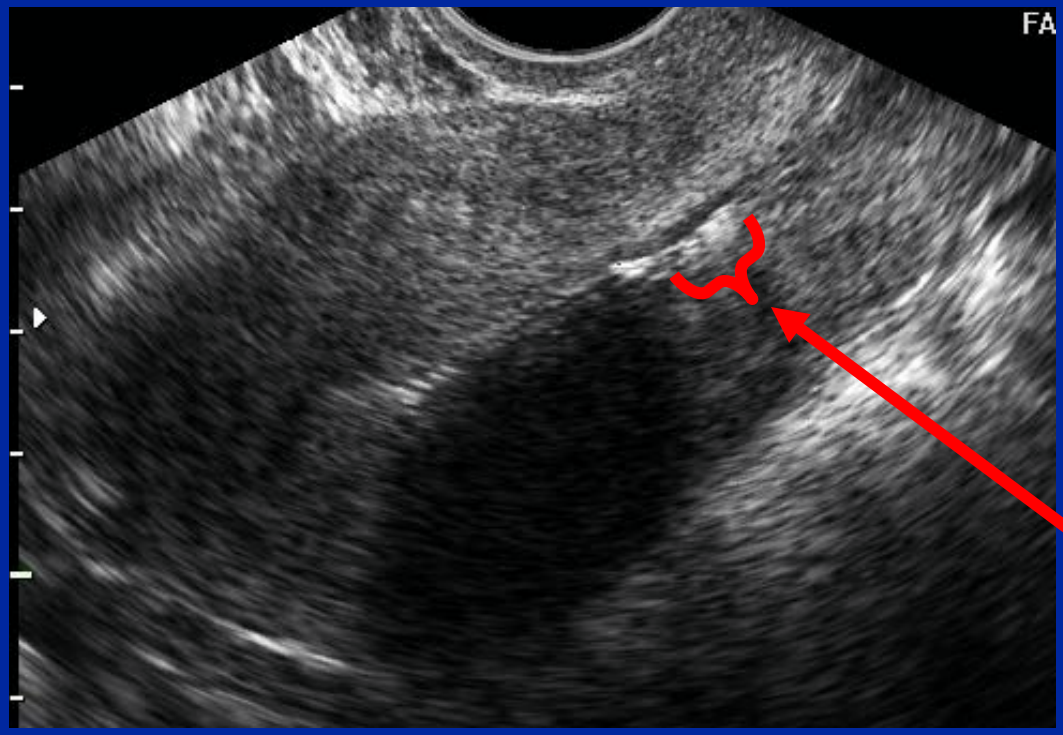


What Is Too Low?



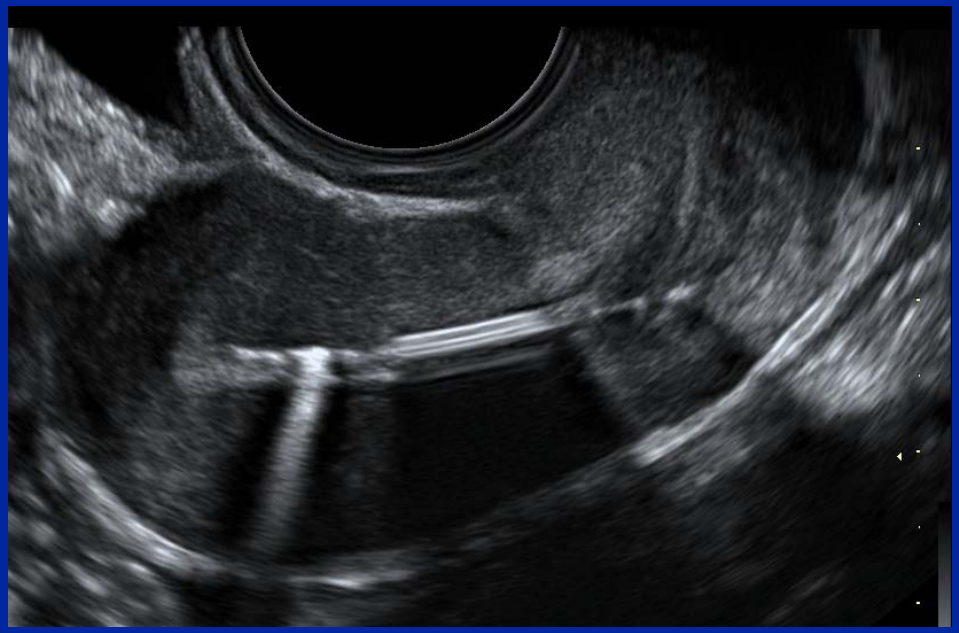
Tip of Mirena extends below internal os

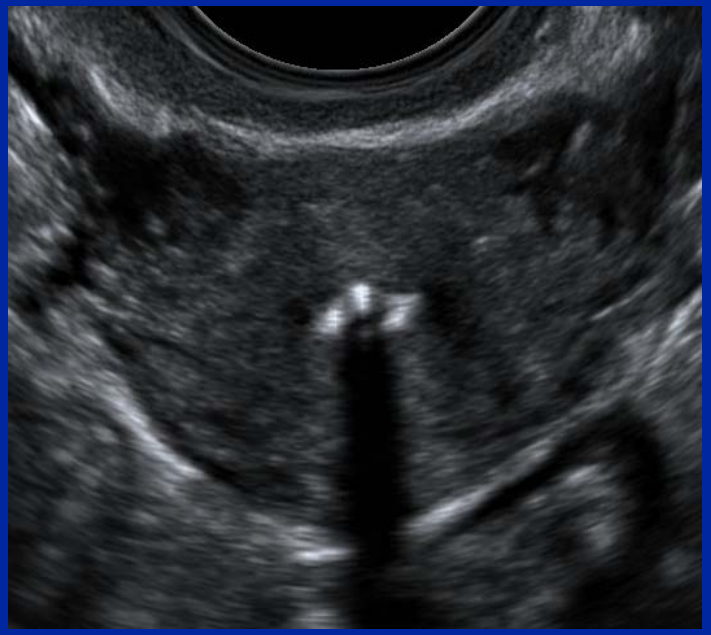
What Is Not Too Low?

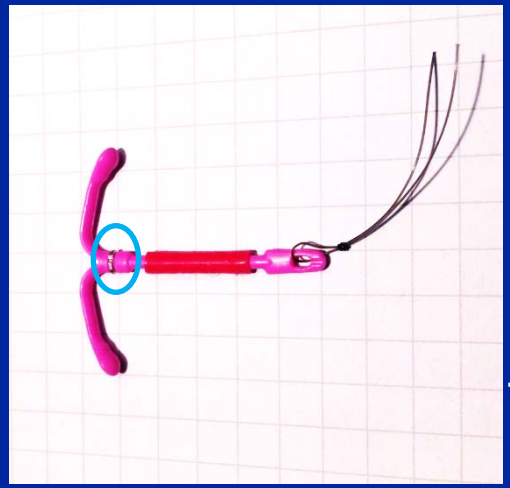


Tip of Mirena well above internal os

Skyla LNG IUS 13.5

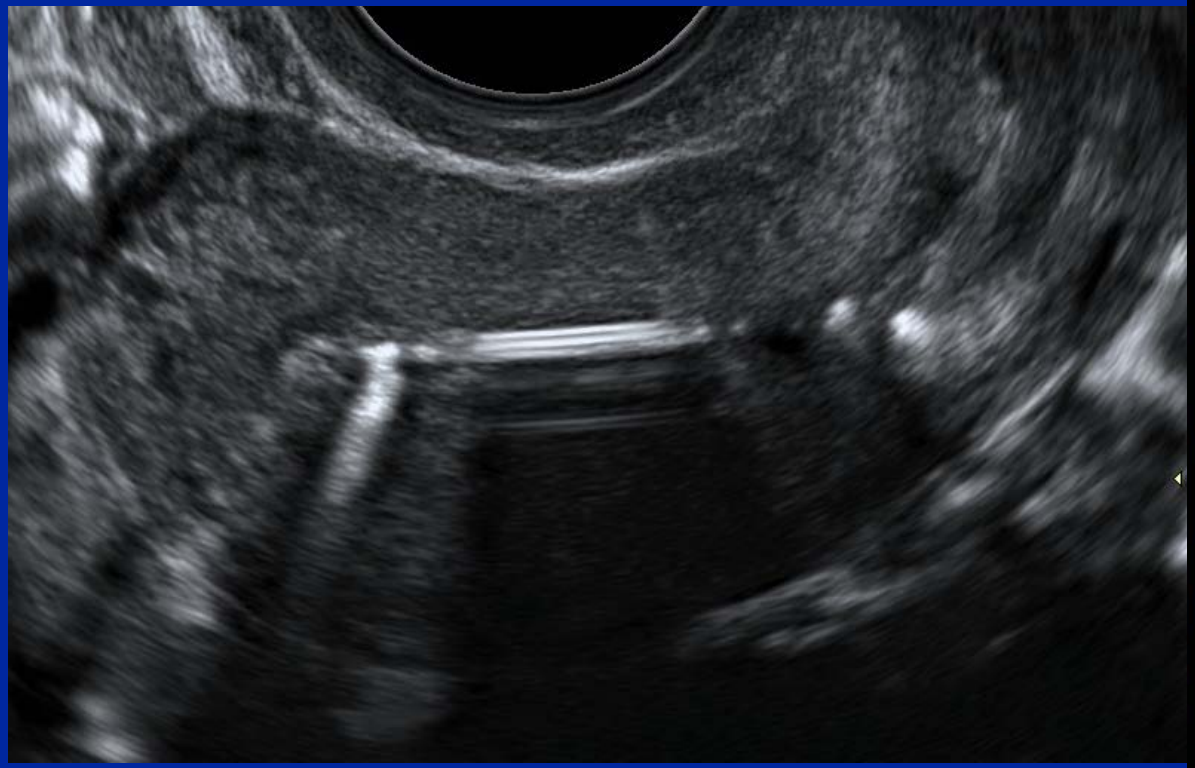


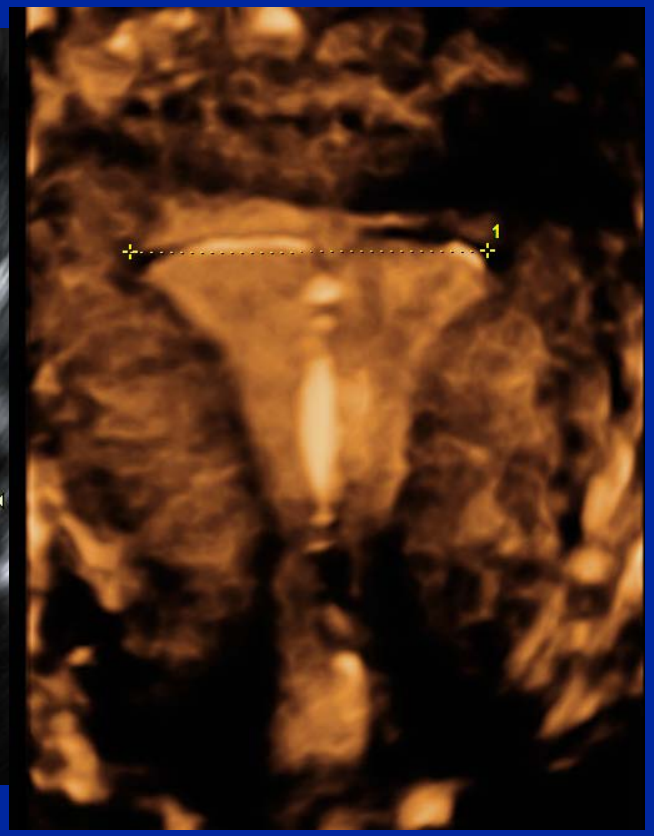




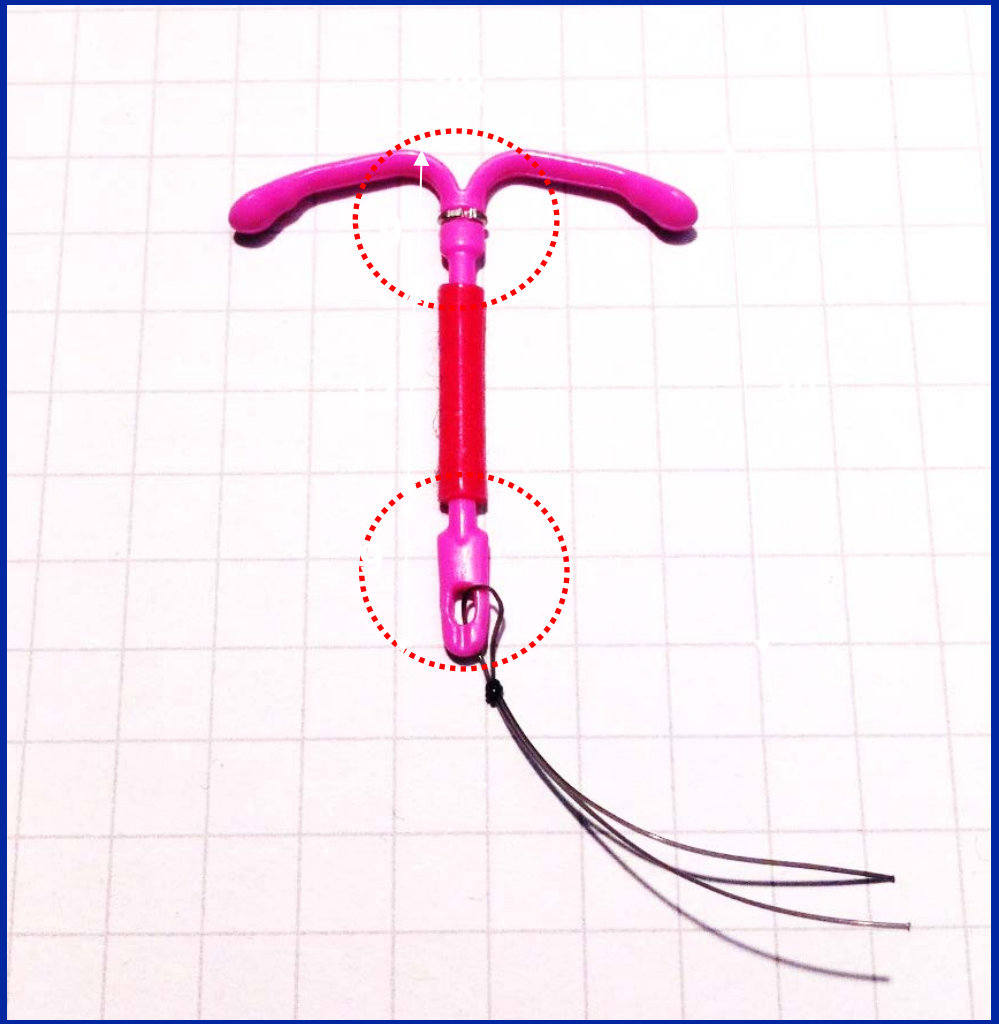
The silver ring

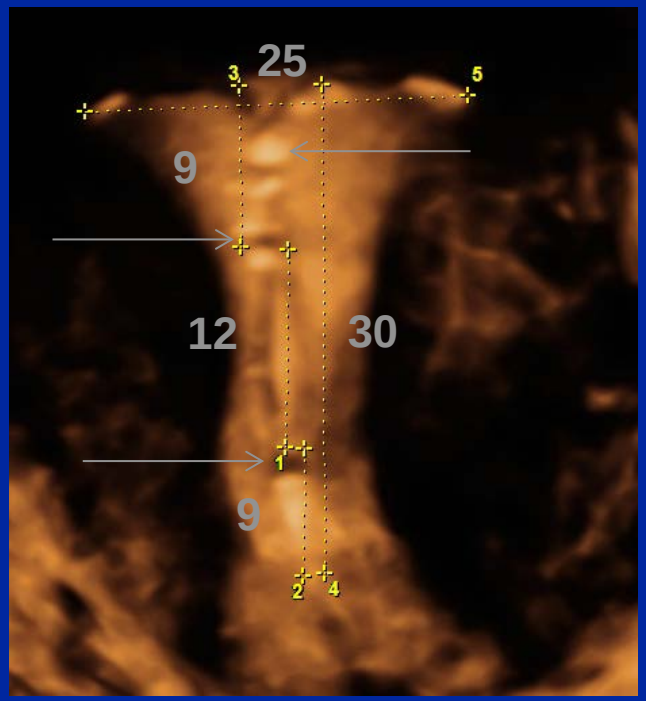
Skyla LNG IUS 13.5



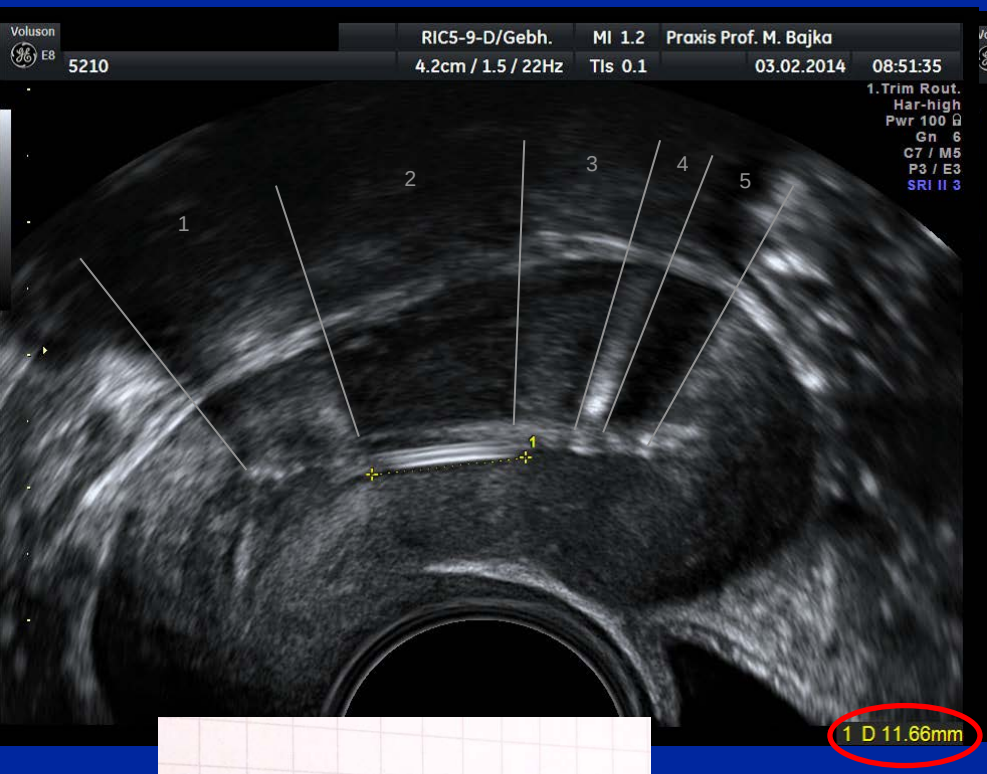


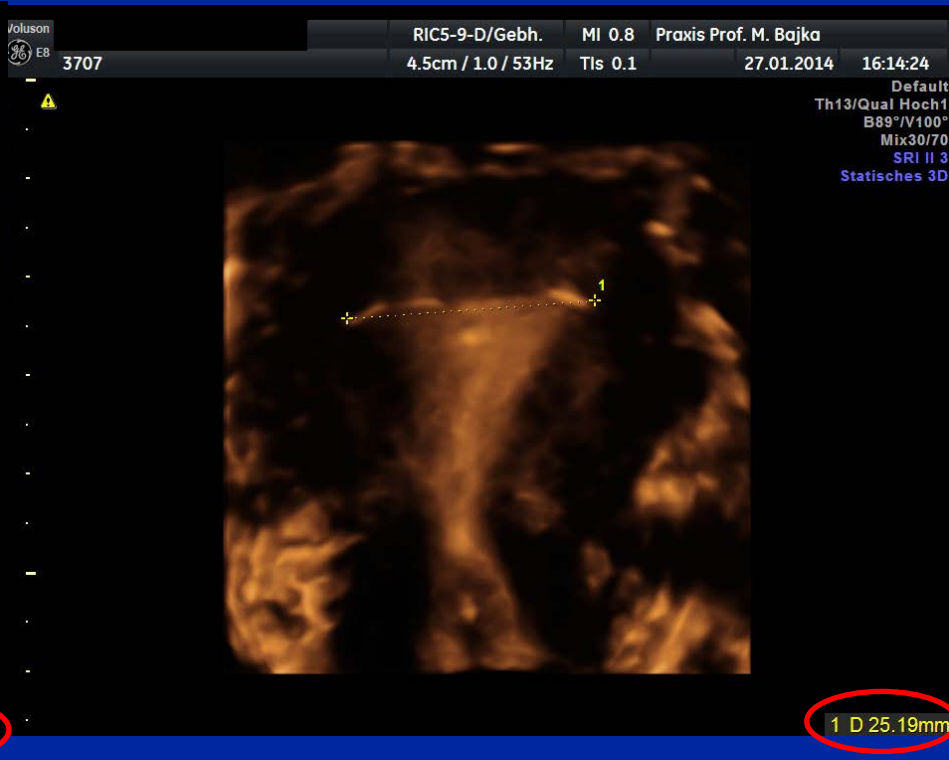
LNG IUS 13.5 Demo Device

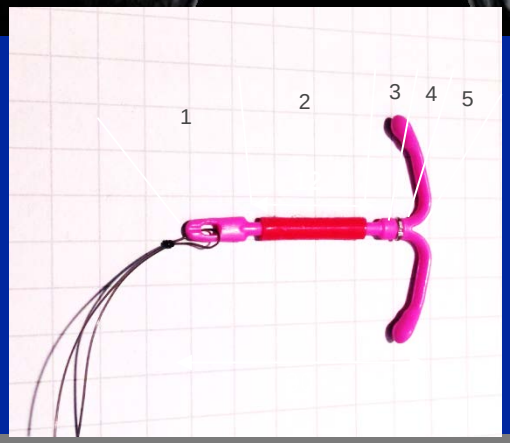




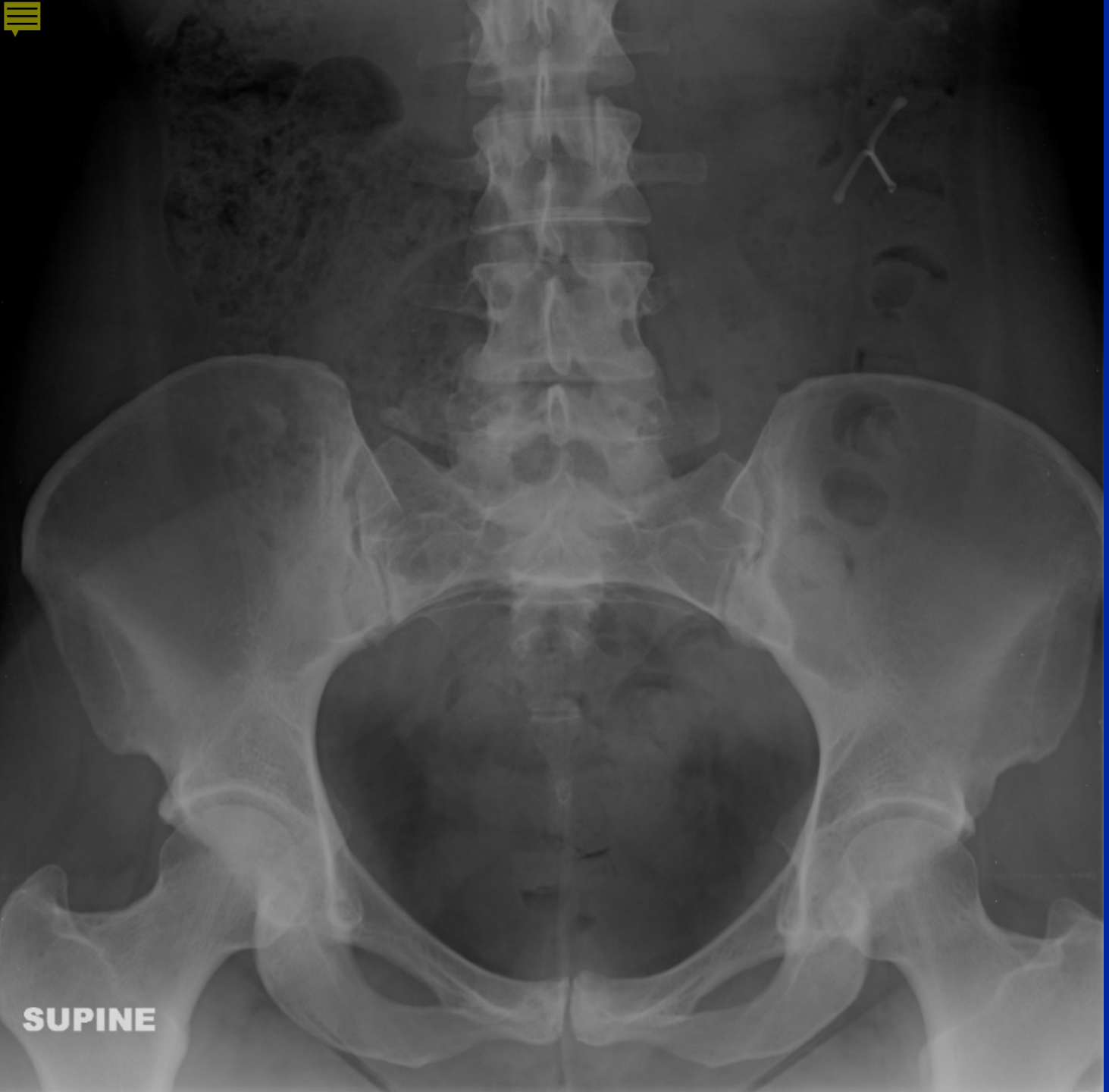
LNG IUS 13.5 Geometry - TVS



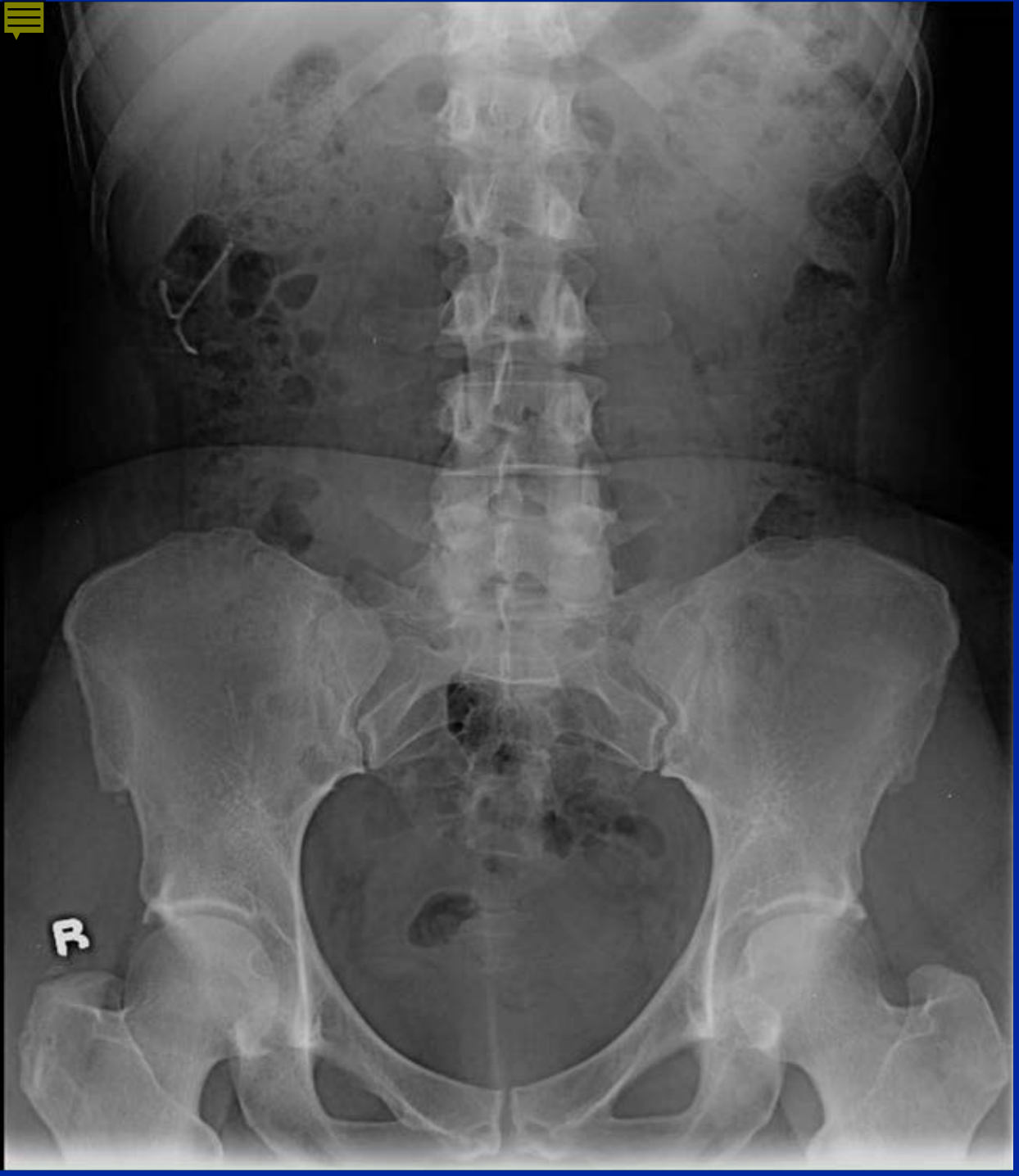




af



On X-ray



On X-ray

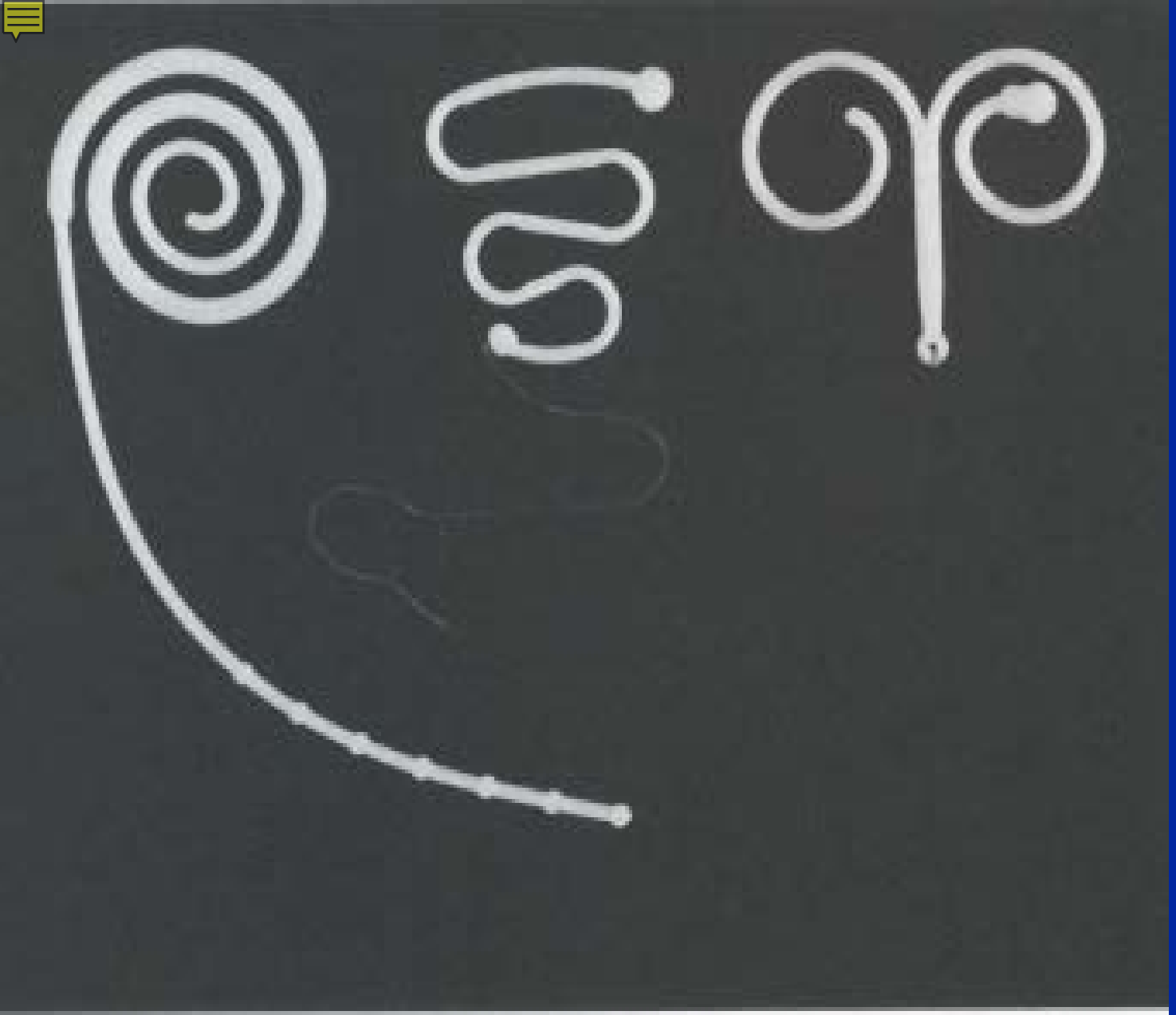
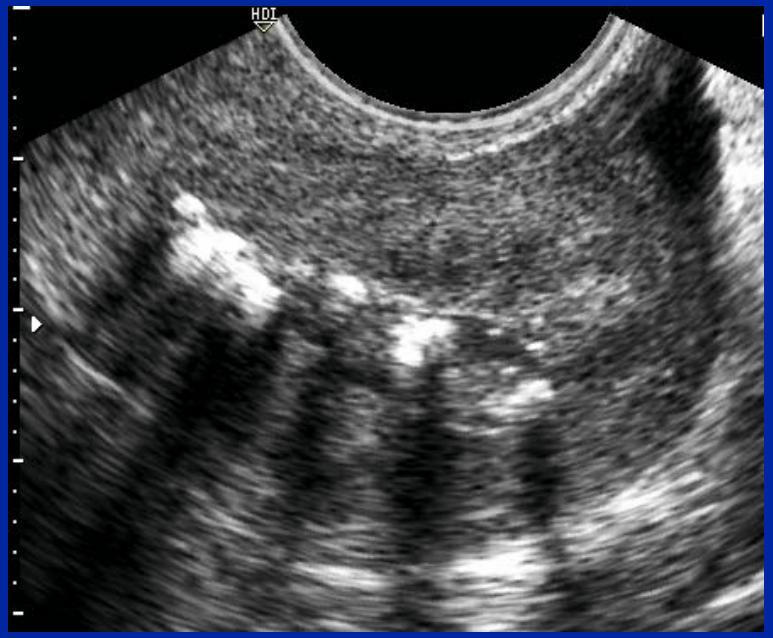


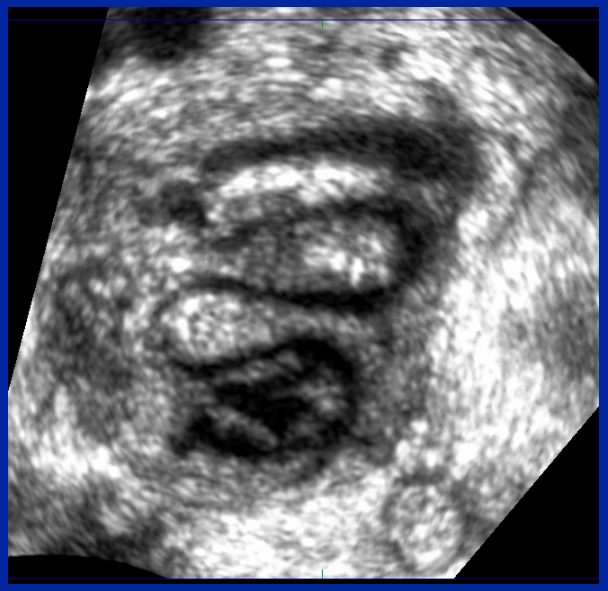
Fig. 1.3: The Margulies Spiral, the Lippes Loop and the Saf-T-Coil.

Plastic IUDs

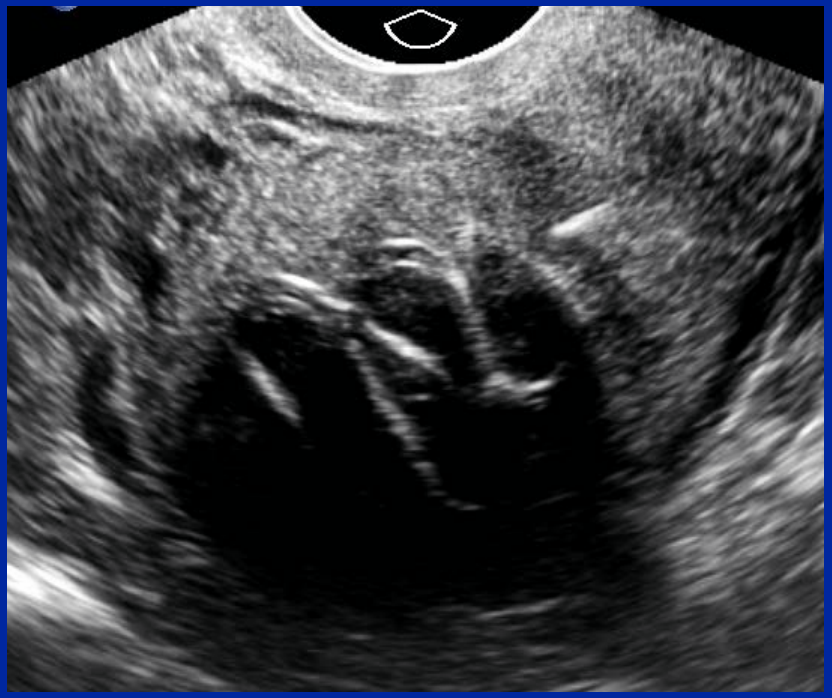
Edelman, 1979

Other IUC Devices

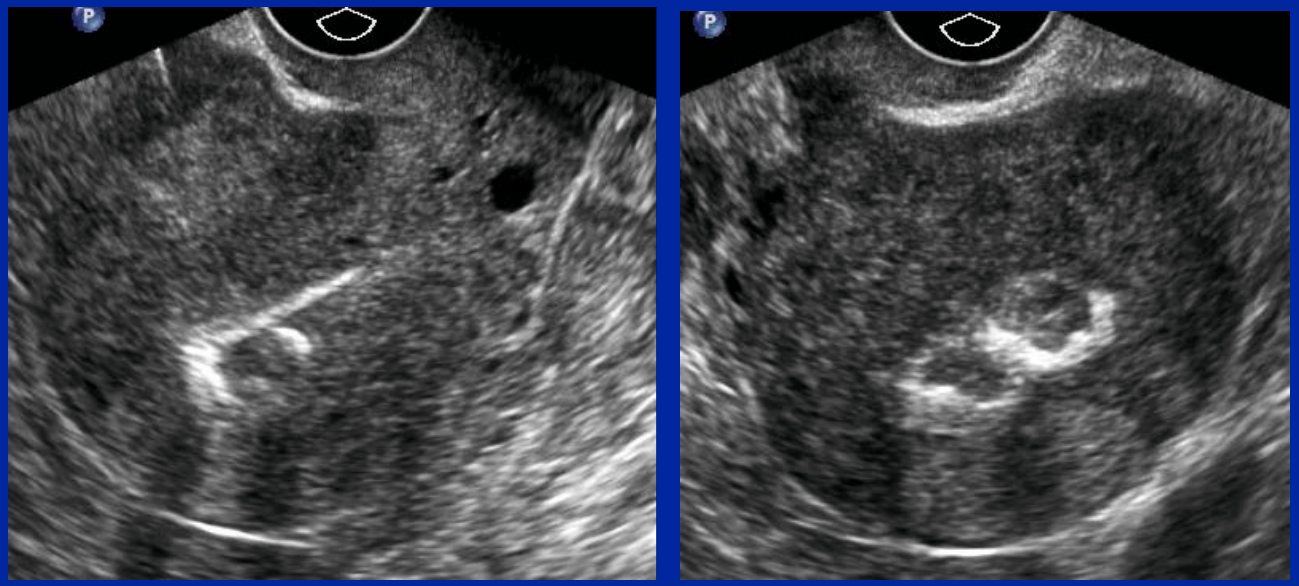




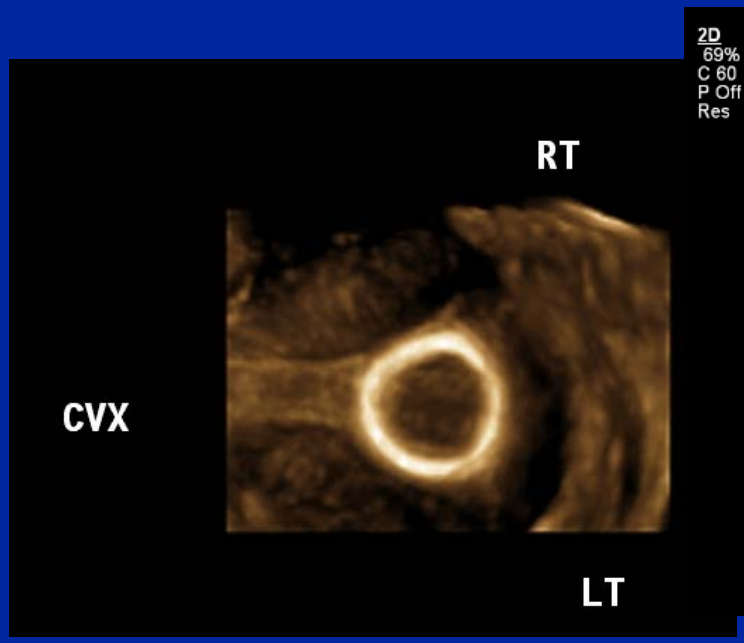
Lippes Loop

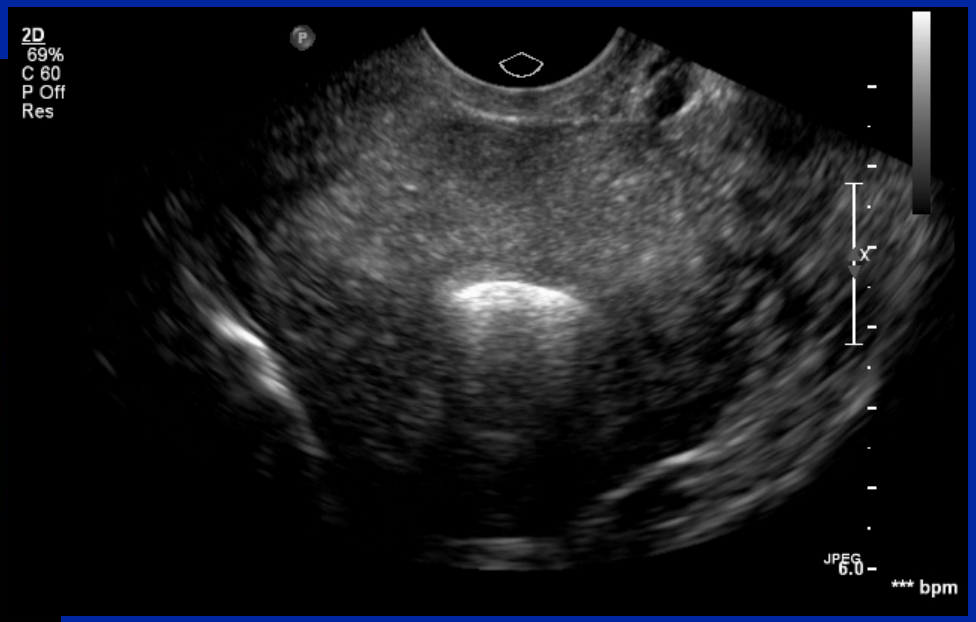


Saf-T-Coil

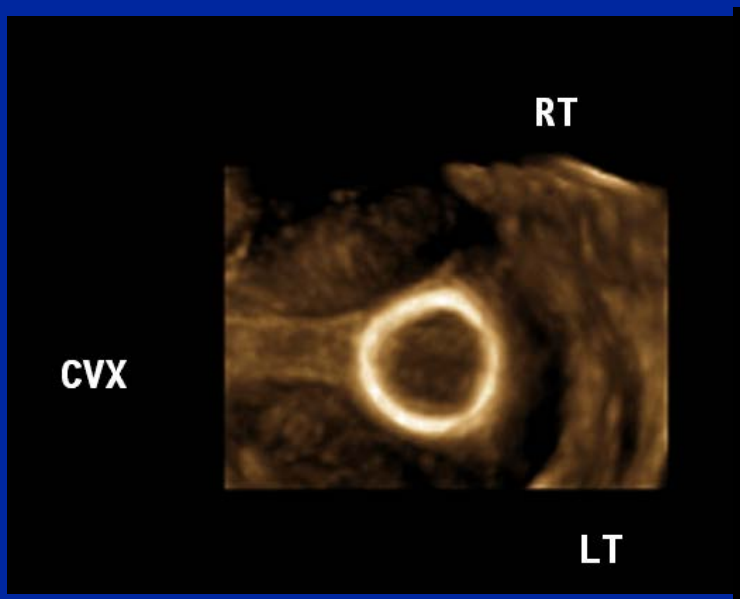


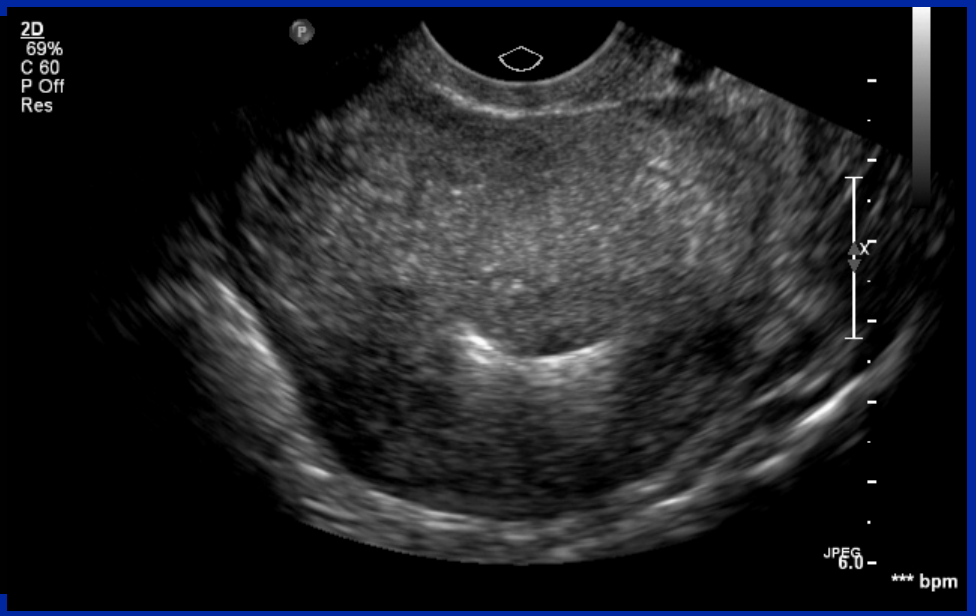
Steel Ring (China)



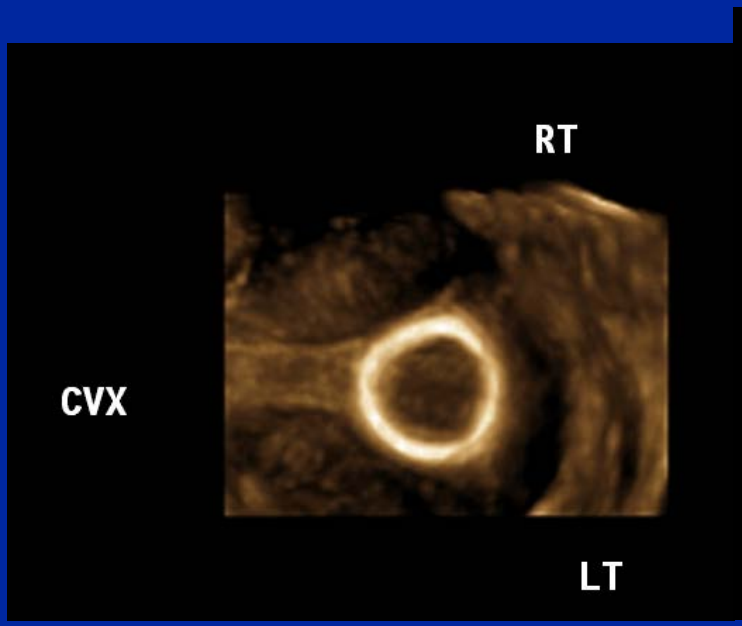


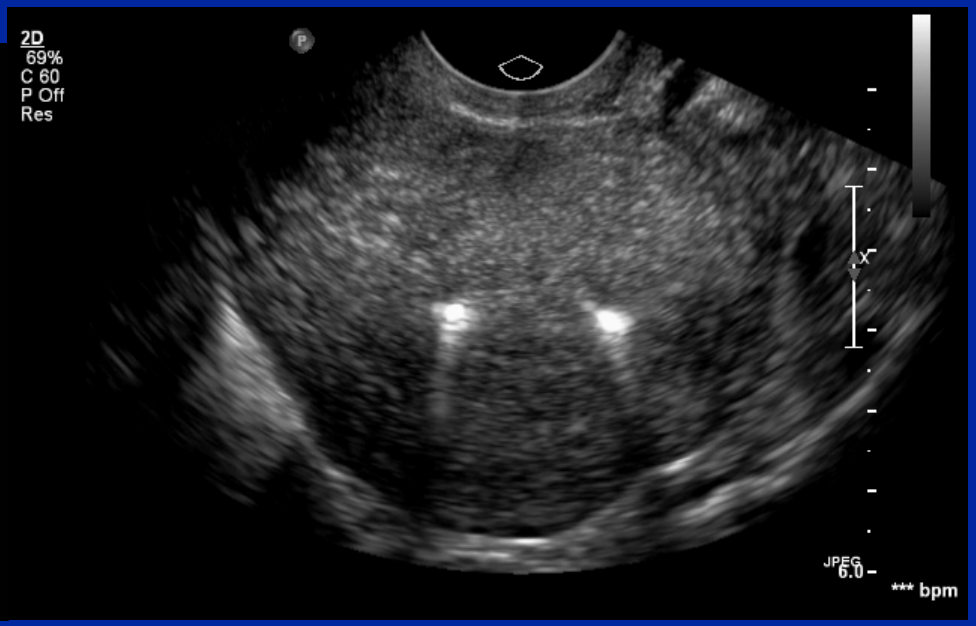
Steel Ring (China)





Steel Ring (China)





Summary

- Copper IUCs are usually easy to see
- Mirena can be hard to see
  - Getting the angle right is key
  - You can use the TV probe to move the uterus to improve visualization

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.
- US 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 IUD
Supply	Check with payer	
Drug	J7301 LNG-IUS, 13.5 mg	Z30.430 Insertion of IUD
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 IUD 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 IUD 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 IUD insertion	
Drug	J7300 (copper IUD)	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 IUD 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 IUD 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 IUD 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 IUD 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	

References

- Abbas, A. M., Abdellah, M. S., Khalaf, M., Bahloul, M., Abdellah, N. H., Ali, M. K., & Abdelmagied, A. M. (2017). Effect of cervical lidocaine-prilocaine cream on pain perception during copper T380A intrauterine device insertion among parous women: A randomized double-blind controlled trial. Contraception, 95(3), 251-256.
- American College of Obstetricians and Gynecologists. Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin no. 121, July 2011. Obstet Gynecol 2011;118:184-96. Reafirmed 2013
- Bahamondes, M. V., Espejo-Arce, X., & Bahamondes, L. (2015). Effect of vaginal administration of misoprostol before intrauterine contraceptive insertion following previous insertion failure: a double blind RCT. *Hum Reprod, 30*(8), 1861-1866.
- Bates, C, Carroll, N and Potter, J. The challenging pelvic examination. JGIM. (2011) 650 – 657.
- Caliskan, E., Ozturk, N., Dilbaz, B. O., & Dilbaz, S. (2003). Analysis of risk factors associated with uterine perforation by intrauterine devices. *Eur J Contracept Reprod Health Care, 8*(3), 150-155.

References

- Cowman, W. L., Hansen, J. M., Hardy-Fairbanks, A. J., & Stockdale, C. K. (2012). Vaginal misoprostol aids in difficult intrauterine contraceptive removal: a report of three cases. *Contraception, 86*(3), 281-284.
- Darney PD. Etonogestrel contraceptive implant www.uptodate.com
- Dean G, Goldberg AB. Management of problems related to intrauterine contraception. www.uptodate.com
- Dermish, A. I., Turok, D. K., Jacobson, J. C., Flores, M. E., McFadden, M., & Burke, K. (2013). Failed IUD insertions in community practice: an under-recognized problem? Contraception, 87(2), 182-186.

References

- Dermish A, Turok DK, Jacobson J, Murphy PA, Saltzman HM, Sanders JN., (2016) Evaluation of an intervention designed to improve the management of difficult IUD insertions by advanced practice clinicians. *Contraception*. Jun;93(6):533-8.
- Dijkhuizen K, Dekkers OM, Holleboom CA, et al. Vaginal misoprostol prior to insertion of an intrauterine device: a randomized controlled trial. Hum Reprod 2011:26:323-9.
- Edelman AB, et al. (2011) Effects of prophylactic misoprostol administration prior to intrauterine device insertion in nulliparous women. Contraception. Contraception. Sep;84(3):234-9

References

- Grubb, B. P. (2005). Clinical practice. Neurocardiogenic syncope. *N Engl J Med, 352*(10), 1004-1010.
- Guney M, Oral B, Mungan T. Efficacy of intrauterine lidocaine for removal of a “lost” intrauterine device: A randomized, controlled trial. Obstet Gynecol 2006;108:119-23.
- Hagemann, C., Heinemann, K., Moehner, S., Reed, S., Unwanted pregnancies among women using intrauterine devices: final results from the Euras-IUD 5-Year Study. *Contraception, 94*(4), 416.

References

- Heinemann, K., Reed, S., Moehner, S., & Minh, T. D. (2015). Comparative contraceptive effectiveness of levonorgestrel-releasing and copper intrauterine devices: the European Active Surveillance Study for Intrauterine Devices. *Contraception, 91*(4), 280-283.
- Heinemann, K., Reed, S., Moehner, S., & Minh, T. D. (2015). Risk of uterine perforation with levonorgestrel-releasing and copper intrauterine devices in the European Active Surveillance Study on Intrauterine Devices. Contraception, 91(4), 274-279.
- Heinemann, K., Reed, S., Moehner, S., & Minh, T. D. (2016). Intrauterine devices and the risk of uterine perforations: final results from the EURAS-IUD 5 years study. *Contraception, 94*(4), 387.

References

- Li YT, Kuo TC, Kuan LC, et al. Cervical softening with vaginal misoprostol before intrauterine device insertion. Int J Gynaecol Obstet 2005;89:67-8.
- Lopez, L. M., Bernholc, A., Zeng, Y., Allen, R. H., Bartz, D., O'Brien, P. A., & Hubacher, D. (2015). Interventions for pain with intrauterine device insertion. *Cochrane Database Syst Rev*(7),
- Kaislasuo, J., Suhonen, S., Gissler, M., Lahteenmaki, P., & Heikinheimo, O. (2012). Intrauterine contraception: incidence and factors associated with uterine perforation--a population-based study. *Hum Reprod, 27*(9), 2658-2663.
- Mansour D. The benefits and risks of using a levonorgestrel-releasing intrauterine system for contraception. Contraception 2012;85:224-34.

References

- Reed, S., Heinemann, K. (2016). Events associated with nexplanon insertion and removal: interim results from the nexplanon observational risk assessment study (NORA). *Contraception, 94*(4), 409.
- Marchi NM, Castro S, Hidalgo M, et al. Management of missing strings in users of intrauterine contraceptives. Contraception 2012;86:354-8.
- NEXPLANON® (etonogestrel implant) Full prescribing information. Merck Revised: 07/2014
- Prabhakaran, S., & Chuang, A. (2011). In-office retrieval of intrauterine contraceptive devices with missing strings. Contraception, 83(2), 102-106.

References

- Renner, R. M., Nichols, M. D., Jensen, J. T., Li, H., & Edelman, A. B. (2012). Paracervical block for pain control in first-trimester surgical abortion: a randomized controlled trial. Obstet Gynecol, 119(5), 1030-1037.
- Renner, R. M., Edelman, A. B., Nichols, M. D., Jensen, J. T., Lim, J. Y., & Bednarek, P. H. (2016). Refining paracervical block techniques for pain control in first trimester surgical abortion: a randomized controlled noninferiority trial. Contraception.
- Saav I, Aronsson A, Marions L, et al. Cervical priming with sublingual misoprostol prior to insertion of an intrauterine device in nulliparous women: a randomized controlled trial. Hum Reprod 2007;22:2647-52.

References

- Swenson C, Turok DK, Ward K, et al. Self-administered misoprostol or placebo before intrauterine device insertion in nulliparous women: a randomized controlled trial. Obstet Gynecol 2012;120: 341-7.
- Swenson, C., Royer, P. A., Turok, D. K., Jacobson, J. C., Amaral, G., & Sanders, J. N. (2014). Removal of the LNG IUD when strings are not visible: a case series. *Contraception, 90*(3), 288-290.
- Turok, D. K., Gurtcheff, S. E., Gibson, K., Handley, E., Simonsen, S., & Murphy, P. A. (2010). Operative management of intrauterine device complications: a case series report. *Contraception, 82*(4), 354-357.

References

- Vickery Z, Madden T. Difficult intrauterine contraception insertion in a nulligravid patient. Obstet Gynecol 2011;117:391-5.
- Ward, K., Jacobson, J. C., Turok, D. K., & Murphy, P. A. (2011). A survey of provider experience with misoprostol to facilitate intrauterine device insertion in nulliparous women. *Contraception, 84*(6), 594-599.

References: Counseling

- ACOG Committee Opinion: Motivational Interviewing: A Tool for behavior Change; 423; Jan 2009.
- Borrero, S., Nikolajski, C., Steinberg, J. R., Freedman, L., Akers, A. Y., Ibrahim, S., & Schwarz, E. B. (2015). "It just happens": a qualitative study exploring low-income women's perspectives on pregnancy intention and planning. Contraception, 91(2), 150-156.
- Dehlendorf C et al. Preferences for decision-making about contraception and general health care among reproductive age women at an abortion clinic. Patient Educ Couns. 2010;81:343–348
- Dehlendorf C et al. Women's preferences for contraceptive counseling and decision making. Contraception. 2013 Aug;88(2):250-6
- Gold Melanie et al. Motivational Interviewing Strategies to facilitate Adolescent Behavior Change. Adoles Health Update. 2007;20(1):1-7.

References: Counseling

- Kennedy, S., et al. (2014). A qualitative study of pregnancy intention and the use of contraception among homeless women with children. *J Health Care Poor Underserved, 25*(2), 757-770.
- Kols AJ, Sherman JE, Piotrow PT. Ethical foundations of client-centered care in family planning. J Womens Health. 1999 Apr;8(3):303-12.
- Langston AM, Rosario L, Westhoff CL. Structured contraceptive counseling — a randomized controlled trial. Patient Educ Couns. 2010;81:362–367.
- Lopez LM et al. Theory-based interventions for contraception. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007249.
- Madden T, et al. Structured contraceptive counseling provided by the Contraceptive CHOICE Project. Contraception. 2013 August; 88(2);243-249.

References: Counseling

- Petersen R, et al. Applying motivational interviewing to contraceptive counseling: ESP for clinicians. Contraception; 69(3):213-7.
- Rinehart W, Rudy S, Drennan M. GATHER guide to counseling. Popul Rep J. 1998;48:1–32.
- Rollnick S, et al. Motivational Interviewing in Health Care. New York: Guilford Press; 2008
- Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception. Am J Ob Gyn 2010;203(115):e111–e117.
- Shih, G., Dube, K., & Dehlendorf, C. (2013). "We never thought of a vasectomy": a qualitative study of men and women's counseling around sterilization. Contraception, 88(3), 376-381.

References: Counseling

- Woodsong, C., Shedlin, M., & Koo, H. (2004). The 'natural' body, God and contraceptive use in the southeastern United States. Cult Health Sex, 6(1), 61-78.
- Yee, L., & Simon, M. (2011). Urban minority women's perceptions of and preferences for postpartum contraceptive counseling. *J Midwifery Womens Health, 56*(1), 54-60.