

Difficult Placement of the Intrauterine Device: Practical Tips and Tricks

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ABSTRACT

Intrauterine devices (IUDs) are recommended as a preferred form of contraception for most women, and demand for the method is growing. IUD placement is usually straightforward, but occasionally can be challenging for both the patient and clinician. This article addresses useful techniques for minimizing the chances of a failed placement.

Keywords: contraception, insertion, intrauterine device, IUD

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The intrauterine device (IUD) is a contraceptive method that is growing in popularity in the United States.¹ Once considered only appropriate for use by parous women, the IUD now has the endorsement of the American College of Obstetricians and Gynecologists as a preferred method for most women, regardless of age or parity.² As public awareness of the method's ease of use, reliability, and safety profile grows, it is no surprise that demand for IUDs is on the rise.

Of the 3 IUDs available on the US market, 2 have explicit Food and Drug Administration approval for use in nulliparous women (Paragard [Teva Pharmaceuticals, Sellersville, PA] and Skyla [Bayer Health Care Pharmaceuticals, Wayne, NJ]). The prescribing information for the third option, Mirena (Bayer Health Care Pharmaceuticals), has wording that does not exclude nulliparous women.

Placement of an IUD is usually as straightforward as following the step-by-step technique spelled out in each device's prescribing information. However, in the case of nulliparous women with narrow cervical canals or in those with other challenging anatomy, some of these placements may be more difficult, and thus patients may find the procedure quite uncomfortable or even intolerable. Clinicians may need to employ additional instrumentation or maneuvers to succeed with the placement. This article presents tips and tricks to help clinicians already familiar with uncomplicated IUD placement in minimizing the number of failed or difficult placements.

EQUIPMENT NEEDS

In addition to the standard equipment needed for routine IUD placement, additional instruments to have on hand for challenging procedures include a set of tapered minidilators, a speculum with short blades, and a para- or intracervical block. Rarely, an 11/12F cervical dilator may also be useful, as well as a flexible endometrial sampling cannula.

PRIOR TO PLACEMENT

Before starting the placement, clinicians should counsel women on what to expect from the procedure. Because anxiety has been found to increase women's perception of pain during the placement, clinicians should specifically address concerns about pain in advance.^{3,4}

Fear of pelvic inflammatory disease caused by sexually transmitted infections used to be considered a valid reason for steering young women away from IUDs. The latest study on the subject shows that, if indicated, screening for chlamydia and gonorrhea can be performed on the day of IUD placement, with no increased risk for uterine infection if positive cases are promptly treated.⁵

IUD CHALLENGES: TIPS AND TRICKS

What follows is a list of clinical scenarios that can make IUD placement more challenging, and tips on how to overcome each challenge. Some of these scenarios require the use of persistence and firmness to succeed in the placement attempt, but at all times

the clinician must bear in mind that avoidance of uterine perforation is paramount. Transvaginal ultrasound may be used after a difficult procedure to verify correct high fundal placement of the device.

The Internal Os Will Not Yield to the Sound

Use the rounded tip of the sound to exert steady, firm pressure against the os. Even if for a long moment it seems like nothing is progressing, the os will usually eventually yield, although it may feel like the sound only advances 1 or 2 mm. With continued gentle, but steady pressure, the os will likely continue to dilate. Utilize the minidilators for the most stenotic internal os that fails to yield to the sound. Start with the narrowest one and gently ease it forward. Once the os yields, move to the next dilator. Pay attention to the angle the dilator follows. Use the dilators and then the sound to establish the passageway for the IUD inserter.

Many providers routinely use preplacement misoprostol for nulliparous women.⁶ Some studies have indicated that this intervention increases the ease of insertion.^{7,8} Other studies have shown no benefit and an increase in side effects.^{9,10} Regimens that have been used include misoprostol 200 to 400 µg sublingually, vaginally, or buccally, self-administered a few hours before the procedure.⁶ In the case of a failed attempt due to cervical stenosis and a patient motivated to try again, the clinician should consider rescheduling the patient and prescribing misoprostol for self-administration prior to the new appointment.⁴

The Uterus Is Retroflexed and Sound Will Not Advance to the Fundus

Retroflexion is a risk factor for perforation, so placement must be conducted extremely carefully. If the bimanual examination reveals a retroflexed uterus and, despite traction on the tenaculum to straighten the uterine axis, the sound fails to advance to an appropriate point, try tipping the handle of the speculum up and bending the sound into a curve. If necessary, the tenaculum can be applied to the posterior lip. If, due to the position of the uterus, the cervix is close to the introitus, a speculum with short blades may be helpful in allowing easier access to the cervix and increased mobility of the uterus.

The Uterus Is Anteфлекed and the Sound Will Not Advance to the Fundus

For overcoming stubborn anteфлекion, use the thumb of the tenaculum hand to push the outside of the speculum downward, so as to raise the blades upward and achieve better alignment with the uterine axis. Maintaining a sterile technique, bend the sound into a curve and use it to gently navigate around the anteфлекion while maintaining strong traction on the tenaculum. Alternately, the clinician can assess the uterine depth using a flexible endometrial sampling device.

The Uterus Sounds to Less Than 6 cm

The uterus must be at least 6 cm in depth to accommodate an IUD. If the sound indicates that the uterine cavity measures less than 6 cm, consider verifying uterine depth via transvaginal ultrasound, as such a finding is quite rare. If confirmed, help the woman choose a different contraceptive method, keeping in mind that the etonogestrel implant is the alternative with the highest effectiveness.

The Sound Goes Through but the IUD Inserter Will Not

In rare cases, the sound goes through but the IUD inserter does not. This is particularly frustrating because it occurs so near to the end of the procedure. There are 2 tricks to try if this happens. The first is to reinsert the sound and gently move it in tiny gentle circles to further dilate the internal os. This helps if the problem is a very tight os. Sometimes, however, the problem involves pronounced folds in the cervical canal that catch the blunt tip of the inserter. In this case, dilating with an 11/12F dilator is usually enough to create a passage for the inserter to go through unimpeded.

The Woman Finds the Placement Too Painful

In a study of nulliparous women receiving the levonorgestrel device, 17% rated the procedure as “severely painful.”¹¹ No single intervention has been shown consistently to reduce the pain potentially associated with the IUD placement procedure. Administration of misoprostol has not been shown to be effective in reducing pain, and has the risk of producing unpleasant side effects, such as cramps

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