**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Intrauterine Contraception - IUD | **No.** |
| **Approved by:**  |  | **Effective Date:**  |
| **Revised Date:** January 2018, January 2019, January 2021, January 2022,October 2022, **January 2024** |
| **References:** U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), 2016; U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR), 2016; Contraceptive Technology, 21st Ed, Society of Family Planning, 2022 |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016; Contraceptive Technology, 21stEd; and the Society of Family Planning, 2022

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in their use of intrauterine devices (IUDs).

IUDs are long acting, reversible contraceptive methods and can be used by clients of all ages, including adolescents, both parous and nulliparous. With typical use, less than 1 out of 100 people who use an IUD becomes pregnant in the first year. Five intrauterine contraceptives are available in the United States: a copper intrauterine device (Cu-IUD), and four levonorgestrel-containing intrauterine devices (LNG-IUDs).

The only nonhormonal IUD currently available in the United States is the copper 380 mm2IUD (Paragard®). Other copper-containing IUDs are available abroad but contain lesser amounts of copper or have a different shape; the information in the CPS is not generalizable to other copper IUDs. The Cu-IUD contains fine copper wire wound around the vertical stem of the T body of the device. Cu-IUD causes an increase in copper ions, enzymes, prostaglandins, and white blood cells in uterine and tubal fluids; these impair sperm function and prevent fertilization. The FDA-approved duration of use is 10 years; however, there is evidence to support its effectiveness through 12 years. Clients may be counseled on extended use of the Cu-IUD, centering their priorities and preferences.

LNG-IUDs (Mirena®, Skyla®, Kyleena®, and Liletta®) contain varying amounts of levonorgestrel (52 mg for Mirena and Liletta, 19.5 mg for Kyleena and 13.5 mg for Skyla), which is released directly into the endometrial cavity. The progestin thickens cervical mucus, suppresses the endometrium, and impairs sperm function. In addition, ovulation is impaired in about 20% of cycles as a result of systemic absorption of levonorgestrel. Mirena and Liletta are FDA-approved for 8 years, Kyleena for 5 years, and Skyla for3 years.

IUDs are not abortifacients; they do not interrupt an implanted pregnancy. Pregnancy is prevented by a combination of the “foreign body effect” of the plastic or metal frame and the specific action of the medication (copper or levonorgestrel) that is released.

IUDs do not protect against sexually transmitted infections (STIs).

**STANDARD:**

(**insert AGENCY name**) MDs, NPs, PAs, DOs, and NDs trained in IUD insertion may provide IUDs to any client who requests this method and has no U.S. MEC category 4 risk conditions. RNs may provide counseling and education related to the IUD.

**PROCEDURE**:

1. Follow the [*Core Reproductive Health Services* *CPS*.](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Core_RH.docx)
2. Follow the [U.S. MEC](https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixb.html) guidelines to determine client eligibility for use of the IUD. If client has any MEC category 3 conditions, an NP, PA, DO, ND, or MD *may* provide the method according to their clinical judgement, if requested by the client. Documentation must show that the client understands the risks of the method and finds other, lower-risk methods unacceptable.
3. Clients requesting a method for which they have a category 4 risk condition will be offered lower risk methods and referred to an OB/GYN or specialist provider.
4. Provide education on warning signs, common side effects, risks, use of method, alternative methods, use of secondary method, and clinic follow-up schedule. Document the client’s education and understanding of the method of choice.

**PLAN**:

1. Initiating the Cu-IUD or the 52mg LNG-IUD:

1. The Cu-IUD or the 52mg LNG-IUD can be inserted at any time if it is reasonably certain that the client is not pregnant.
2. The Cu-IUD or the 52mg LNG-IUD also can be inserted within 5 days of the first act of unprotected sexual intercourse as an emergency contraceptive. See [*Emergency Contraception CPS.*](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-EC.docx)
3. If the day of ovulation can be estimated, the Cu-IUD or the 52mg LNG-IUD also can be inserted > 5 days after sexual intercourse as long as insertion does not occur > 5 days after ovulation.
4. No additional contraceptive protection is needed after Cu-IUD or the 52mg LNG-IUD insertion as it is effective immediately.
5. Special Considerations:

Amenorrhea (Not Postpartum):

1. The Cu-IUD or the 52mg LNG-IUD can be inserted at any time if it is reasonably certain that the client is not pregnant.

Postpartum (including after Cesarean Section):

1. The Cu-IUD or the 52mg LNG-IUD can be inserted immediately postpartum (U.S. MEC 1 or 2) or at any other time in the postpartum period if it is reasonably certain that the client is not pregnant. Perforation rates are higher if inserted between the immediate postpartum period and 6 weeks postpartum.

Postabortion (Spontaneous or Induced):

1. The Cu-IUD or the 52mg LNG-IUD can be inserted with the first 7 days, including immediately postabortion (U.S. MEC 1 for first trimester abortion and U.S. MEC 2 for second trimester abortion).
2. Switching from another contraceptive method:

The Cu-IUD can be inserted immediately if it is reasonably certain that the client is not pregnant. Waiting for the next menstrual period is not necessary.

In situations where the medical provider is not reasonably certain that the client is not pregnant, the client should be provided with another contraceptive method to use until the health-care provider can be reasonably certain that they are not pregnant.

1. Initiating the 19.5mg or the 13.5mg LNG-IUD:
2. The 19.5mg or 13.5mg LNG-IUD can be inserted at any time if it is reasonably certain that the client is not pregnant.
3. If the 19.5mg or 13.5mg LNG-IUD is inserted within the first 7 days since menstrual bleeding started, immediately after a procedural abortion, or in specific postpartum situations (defined below) no additional contraceptive protection is needed. In all other cases the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
4. Special Considerations:

Amenorrhea (Not Postpartum):

1. The 19.5mg or 13.5mg LNG-IUD can be inserted at any time if it is reasonably certain that the client is not pregnant.

Postpartum (including after Cesarean Section):

1. The 19.5mg or 13.5mg LNG-IUD can be inserted at any time, including immediately postpartum (U.S. MEC 1 or 2) if it is reasonably certain that the client is not pregnant. Perforation rates are higher if inserted between the immediate postpartum period and 6 weeks postpartum.
2. If the client is < 6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [85%] of feeds are breastfeeds) no additional contraceptive protection is needed.
3. A client, who is ≥ 21 days postpartum and has not experienced the return of a menstrual cycle, needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
4. If a menstrual cycle has returned and it has been > 7 days since menstrual bleeding began, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
* Postabortion (Spontaneous or Induced):
1. The 19.5mg or 13.5mg LNG-IUD can be inserted within the first 7 days, including immediately postabortion (U.S. MEC 1 for first-trimester abortion and U.S. MEC 2 for second-trimester abortion).
2. Switching From Another Contraceptive Method:

The 19.5mg or 13.5mg LNG-IUD can be inserted immediately if it is reasonably certain that the client is not pregnant. Waiting for the next menstrual period is not necessary.

Switching from a Cu-IUD:

1. If the client has had sexual intercourse since the start of their current menstrual cycle and it has been > 5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A healthcare provider can consider providing any type of EC pills at the time of LNG-IUD insertion.

In situations where the medical provider is not reasonably certain that the client is not pregnant, the client should be provided with another contraceptive method to use until the healthcare provider can be reasonably certain that they are not pregnant.

1. If a client needs to use additional contraceptive protection when switching to 19.5mg or 13.5mg LNG-IUD, consider continuing their previous method for 7 days after insertion.

Placement:

1. Review the IUD placement procedure with the client.
2. Obtain written consent for the procedure and for use of the device.
3. Provide pain management as appropriate for the client. Studies have shown that paracervical block with lidocaine may reduce pain during IUD insertion. Note that misoprostol is **not** recommended for routine use before IUD insertion. Misoprostol might be helpful in select circumstances (e.g., in clients with a recent failed insertion/history of cesarean section).
4. Perform a careful bimanual examination to confirm direction of the uterus and its axial length.
5. Insert the speculum and assess for mucopurulent cervicitis or genital anomaly.
6. Many clinicians wash the cervix with an antiseptic, such as povidone-iodine or chlorhexidine. However, no evidence supports this practice and its effects on bacterial colony counts in the endocervix is minimal.
7. Apply a tenaculum or Allis clamp to the anterior or posterior lip of the cervix and apply gentle traction to the tenaculum to straighten the axis of the uterus. Position the tenaculum or Allis to maximize straightening of the endocervical canal and uterus.
8. Sound the uterus prior to placing the IUD.
9. Follow the manufacturer’s instructions from the package insert on how to load and place the IUD. The IUD should be placed at the fundus of the uterine cavity. If there is a clinical concern that the IUD is not in the correct position, check the placement (with ultrasound, if necessary). If IUD is not positioned correctly remove it and replace with a new IUD.

Removal:

1. Intrauterine contraceptives should be removed only by a prescribing provider who has been trained in IUD removal.
2. Unless pregnancy is desired, an alternative method of contraception should be offered.
3. If the client has had sexual intercourse since the start of their current menstrual cycle and it has been > 5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A healthcare provider can consider providing any type of EC pills at the time of an IUD removal.
4. Another IUD may be inserted immediately after removal.
5. If pregnancy is desired, provide preconception counseling and advise client to begin taking a daily prenatal vitamin with 0.4 to 0.8 milligrams of folic acid at least 30 days before trying to become pregnant.

**ROUTINE FOLLOW-UP:**

1. The recommendations listed below address when routine follow-up is recommended for safe and effective continued use of contraception for healthy clients. The recommendations might vary for different users and different situations. Specific populations such as adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions may benefit from more frequent follow-up visits.
2. Advise the client to return at any time to discuss side effects or other problems, if they want to change the method being used, and when it is time to remove or replace the contraceptive method. No routine follow-up visit is required.
3. At other routine visits, health-care providers who see IUD users should do the following:

Assess the client’s satisfaction with their contraceptive method and whether there are any concerns about method use.

Assess any changes in health status, including medications that would change the appropriateness of the IUD for safe and effective continued use on the basis of U.S. MEC (e.g., category 3 & 4 risk conditions and characteristics).

Consider performing an examination to check for the presence of the IUD strings.

Consider assessing weight changes and counseling clients who are concerned about weight changes perceived to be associated with their contraceptive method.

Management of Missing Strings:

1. Advise clients to return for an evaluation if they are unable to feel the IUD strings.
2. Missing strings may indicate:

Unsuspected perforation;

Spontaneous expulsion; alternately

May ascend into the endometrial cavity and descend without known explanation

1. If ultrasonography is available, consider performing. If not, refer for an ultrasound examination to determine the location of the IUD.

If you are unable to confirm intrauterine placement in the office, counsel the client to abstain from intercourse, or use a backup method of contraception, until location can be confirmed.

1. If IUD is in the endometrial cavity, it may be left in place; no additional surveillance or follow-up is required.
2. If IUD is not visible in the uterus with ultrasound, refer for an abdominal X-ray to determine whether the IUD has been expelled or perforated into the peritoneal cavity.

If IUD was expelled

1. offer client emergency contraception, if needed
2. Offer and provide a new IUD when expulsion is diagnosed if client desires.

If IUD is displaced or malpositioned, (but not in the cervix), assess if client is asymptomatic. If asymptomatic, removal is not necessary.

If a copper IUD is found outside the endometrial cavity, it should be removed promptly, because copper in the peritoneal cavity induces adhesion formation.

No clear medical indication exists for removal of IUDs that do not contain copper, although this is commonly done.

Management of Bleeding Irregularities:

1. **Cu-IUD:**
2. Prior to Cu-IUD insertion, provide counseling about potential changes in bleeding patterns during Cu-IUD use. Unscheduled spotting or light bleeding, as well as heavy or prolonged bleeding, is common during the first 3-6 months of Cu-IUD use, is generally not harmful, and decreases with continued Cu-IUD use.
3. If clinically indicated, consider an underlying gynecological problem, such as Cu-IUD displacement, a STI, pregnancy or new pathologic uterine conditions, especially with clients who have been using the Cu-IUD for a few months or longer and who have developed a new onset of heavy or prolonged bleeding.

Refer to the prescribing provider/primary care provider for evaluation.

1. If an underlying gynecological problem is not found and the client requests treatment, the following treatment options can be considered during days of bleeding:

Nonsteroidal anti-inflammatory drugs (NSAIDs) for short-term treatment (5-7 days); and

If bleeding persists and the client finds it unacceptable, counsel them on alternative methods, and offer another method if desired.

1. **LNG-IUD**:
2. Prior to the insertion of LNG-IUD, provide counseling about potential changes in bleeding patterns during LNG-IUD use. Unscheduled spotting or light bleeding, as well as heavy or prolonged bleeding, is common during the first 3-6 months of LNG-IUD use, is generally not harmful, and decreases with continued LNG-IUD use.

Over time, bleeding generally decreases with LNG-IUD use, and many clients experience only light menstrual bleeding or amenorrhea.

Heavy or prolonged bleeding, either unscheduled or menstrual, is uncommon during LNG-IUD use.

1. Irregular bleeding (Spotting, Light Bleeding, or Heavy or Prolonged Bleeding):

If clinically indicated, consider an underlying gynecological problem, such as LNG-IUD displacement, a STI, pregnancy or new pathologic uterine condition.

1. Refer to the prescribing provider/PCP for evaluation.

If bleeding persists and the client finds it unacceptable, counsel them on alternative contraceptive methods, and offer another method if it is desired.

1. Amenorrhea:

Amenorrhea does not require any medical treatment. Provide reassurance.

1. If a client’s regular bleeding pattern changes abruptly to amenorrhea, consider ruling out pregnancy, if clinically indicated.

If amenorrhea persists and the client finds it unacceptable, counsel them on alternative contraceptive methods, and offer another method if it is desired.

Management Of The IUD When User Is Found To Have Pelvic Inflammatory Disease (PID):

1. Treat PID according to the [*CDC Sexually Transmitted Diseases Treatment Guidelines, 2021.*](https://www.cdc.gov/std/treatment-guidelines/pid.htm)
2. Provide comprehensive management for STIs, including counseling about condom use.
3. The IUD does not need to be removed immediately if the client needs ongoing contraception.
4. Reassess the client in 48-72 hours. If no clinical improvement occurs, continue antibiotics and consider removal of the IUD.
5. If the client wants to discontinue use, remove the IUD sometime after antibiotics have been started to avoid the potential risk for bacterial spread resulting from the removal procedure.
6. If the IUD is removed, consider EC pills if appropriate. Counsel the client on alternative contraceptive methods and offer another method if it is desired.
7. Hormonal contraceptive can be started immediately after use of ECPs (with the exception of UPA). Hormonal contraceptive can be started no sooner than 5 days after using UPA.

Management When User is Found to be Pregnant:

1. Evaluate for possible ectopic pregnancy.
2. Advise the client that they have an increased risk for spontaneous abortion (including septic abortion that might be life threatening) and of preterm delivery if the IUD is left in place. Removing the IUD improves pregnancy outcomes and should be removed if the IUD strings are visible or the device can be retrieved safely from the cervical canal.
3. The removal of the IUD reduces these risks but might not decrease the risk to the baseline level of a pregnancy without an IUD.
4. If IUD strings are visible:
	1. Advise the client that the IUD should be removed as soon as possible.

If the IUD is to be removed, remove it by pulling on the strings gently.

Advise the client to return promptly if they have heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

* 1. If the client chooses to keep the IUD, advise them to seek care promptly if they have heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.
1. IUD strings are not visible:
2. If ultrasonography is available, consider performing or referring for an ultrasound examination to determine the location of the IUD.
3. If ultrasonography is not possible or the IUD is determined by an ultrasound to be inside the uterus, advise the client to seek care promptly if they have heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever. Clients planning to continue their pregnancy should be advised to seek prenatal care as soon as possible.
4. Follow the [*Pregnancy Test Visit CPS*](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Pregnancy_Test_Visit.docx) for options counseling and referral as indicated.

**CLIENT EDUCATION:**

1. Instruct the client to check strings monthly—this allows them to be aware of string length and any changes to strings indicating perforation or expulsion.
2. Advise the client to contact the clinic with any questions about their contraceptive method.
3. Inform the client that any signs and symptoms of complications should be reported to the health center; if the health center is not open, the client should call 911 or go to the emergency room.
4. Provide the client with the manufacturer’s card with the date the IUD is to be removed.

**REFERENCES:**

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