

Expert advice for immediate postpartum LARC insertion

In this article: Who is the ideal patient for postpartum LARC; insertion technique, including avoiding common pitfalls; and tips for implementing immediate postpartum LARC within one's own institution

Q&A with Lisa Hofler, MD, MPH, MBA

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Evidence-based education about long-acting reversible contraception (LARC) for women in the postpartum period can result in the increased continuation of and satisfaction with LARC.¹ However, nearly 40% of women do not attend a postpartum visit.² And up to 57% of women report having unprotected intercourse before the 6-week postpartum visit, which increases the risk of unplanned pregnancy.³ The American College of Obstetricians and Gynecologists supports immediate postpartum LARC insertion as best practice,³ and clinicians providing care for women during the peripartum period can counsel women regarding informed contraceptive decisions and provide guidance regarding both short-acting contraception and LARC.¹

Immediate postpartum LARC, using intrauterine devices (IUDs) in particular, has been used around the world for a long time, says Lisa Hofler, MD, MPH, MBA, Chief in the Division of Family Planning at the University of New Mexico School of Medicine in Albuquerque. "Much of our initial data came from

other countries, but eventually people in the United States said, "This is a great option, why aren't we doing this?" In addition, although women considering immediate postpartum LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, the evidence overwhelmingly has not shown a negative effect on actual breastfeeding outcomes according to ACOG.³ OBG MANAGEMENT recently met up with Dr. Hofler to ask her which patients are ideal for postpartum LARC, how to troubleshoot common pitfalls, and how to implement the practice within one's own institution.

OBG MANAGEMENT: Who do you consider to be the ideal patient for immediate postpartum LARC?

Lisa Hofler, MD, MPH, MBA: The great thing about immediate postpartum LARC (including IUDs and implants) is that any woman is an ideal candidate. We are simply talking about the timing of when a woman chooses to get an IUD or an implant after the birth of her child. There is no one perfect woman; it is the person who chooses the method and wants to use that method immediately after birth. When a woman chooses a LARC, she can be assured that after the birth of her child she will be protected against pregnancy. If she chooses an IUD as her LARC method, she will be comfortable at insertion because the cervix is already dilated when it is inserted.



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TABLE US Medical Eligibility Criteria classification of immediate postpartum LARC³

US MEC category	Description
Intrauterine device	
1 (A condition for which there is no restriction for the use of the contraceptive method)	Immediate postpartum IUD insertion
2 (A condition for which the advantages of using the method generally outweigh the theoretical or proven risks)	Immediate postpartum levonorgestrel (LNG)-IUD insertion in breastfeeding women
2	Copper or LNG-IUD insertion from 10 minutes after placental delivery to 4 weeks postpartum
1	Copper or LNG-IUD insertion at or after 4 weeks postpartum
4 (A condition that represents an unacceptable health risk if the contraceptive method is used)	Uterine infection or ongoing postpartum hemorrhage
Implant	
1	Insertion in nonbreastfeeding women less than 21 days postpartum
2	Insertion in breastfeeding women less than 30 days postpartum
1	Insertion in breastfeeding women beyond 30 days postpartum

For the implant, the contraindications are the same as in the outpatient setting. The Centers for Disease Control and Prevention's Medical Eligibility Criteria for Contraceptive Use covers many medical conditions and whether or not a person might be a candidate for different birth control methods.⁴ Those same considerations apply for the implant postpartum (TABLE).³

For the IUD, similarly, anyone who would not be a candidate for the IUD in the outpatient setting is not a candidate for immediate postpartum IUD. For instance, if the person has an intrauterine infection, you should not place an IUD. Also, if a patient is hemorrhaging and you are managing the hemorrhage (say she has retained placenta or membranes or she has uterine atony), you are not going to put an IUD in, as you need to attend to her bleeding.

OBG MANAGEMENT: What is your approach to counseling a patient for immediate postpartum LARC?

Dr. Hofler: The ideal time to counsel about postbirth contraception is in the prenatal period, when the patient is making decisions about what method she wants to use after

the birth. Once she chooses her preferred method, address timing if appropriate. It is less ideal to talk to a woman about the option of immediate postpartum LARC when she comes to labor and delivery, especially if that is the first time she has heard about it. Certainly, the time to talk about postpartum LARC options is not immediately after the baby is born. Approaching your patient with, "What do you want for birth control? Do you want this IUD? I can put it in right now," can feel coercive. This approach does not put the woman in a position in which she has enough decision-making time or time to ask questions.

OBG MANAGEMENT: What problems do clinicians run into when placing an immediate postpartum IUD, and can you offer solutions?

Dr. Hofler: When placing an immediate postpartum IUD, people might run into a few problems. The first relates to preplacement counseling. Perhaps when making the plan for the postpartum IUD the clinician did not counsel the woman that there are certain conditions that could preclude IUD placement—such as intrauterine infection or postpartum

FAST TRACK

Counsel patients prenatally about the contraindications to immediate postpartum IUD placement (intrauterine infection and postpartum hemorrhage) and make a back-up plan

Levonorgestrel vs copper IUD expulsion rates after immediate postpartum insertion

A 2017 prospective cohort study was the first to directly compare expulsion rates of the levonorgestrel (LNG) intrauterine device (IUD) and the copper IUD placed postplacentally (within 10 minutes of placental delivery). The study investigators found that, among 96 women at 12 weeks, 38% of the LNG-IUD users and 20% of the copper IUD users experienced IUD expulsion (odds ratio, 2.55; 95% confidence interval [CI], 0.99–6.55; $P = .05$). Women were aged 18 to 40 and had a singleton vaginal delivery at ≥ 35 weeks' gestation.¹ The two study groups were similar except that more copper IUD users were Hispanic (66% vs 38%) and fewer were primiparous (16% vs 31%). The study authors found the only independent predictor of device expulsion to be IUD type.

In a 2019 prospective cohort study, Hinz and colleagues compared the 6-month expulsion rate of IUDs inserted in the immediate postpartum period (within 10 to 15 minutes of placental delivery) after vaginal or cesarean delivery.² Women were aged 18 to 45 years and selected a LNG 52-mg IUD (75 women) or copper IUD (58 women) for postpartum contraception. They completed a survey from weeks 0 to 5 and on weeks 12 and 24 postpartum regarding IUD expulsion, IUD removal, vaginal bleeding, and breastfeeding. A total of 58 women had a vaginal delivery, and 56 had a cesarean delivery.

At 6 months, the expulsion rates were similar in the two groups: 26.7% of the LNG-IUDs expelled, compared with 20.5% of the copper IUDs ($P = .38$). The study groups were similar, point out the study investigators, except that the copper IUD users had a higher median parity (3 vs 2; $P = .03$). In addition, the copper IUDs were inserted by more senior than junior residents (46.2% vs 22.7%, $P = .02$).

A 2018 systematic review pooled absolute rates of IUD expulsion and estimated adjusted relative risk (RR) for IUD type. A total of 48 studies (rated from poor to good quality) were included in the analysis, and results indicated that the LNG-IUD was associated with a higher risk of expulsion at less than 4 weeks postpartum than the copper IUD (adjusted RR, 1.91; 95% CI, 1.50–2.43).³

References

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hemorrhage. When dealing with those types of issues, a patient is not eligible for an IUD, and she should be mentally prepared for this type of situation. Let her know during the counseling before the birth that immediately postpartum is a great time and opportunity for effective contraception placement. Tell her that hopefully IUD placement will be possible but that occasionally it is not, and make a back-up plan in case the IUD cannot be placed immediately postpartum.

The second unique area for counseling with immediate postpartum IUDs is a slightly increased risk of expulsion of an IUD placed immediately postpartum compared with in the office. The risk of expulsion varies by type of delivery. For instance, cesarean delivery births have a lower expulsion rate than vaginal births. The expulsion rate seems to vary by type of IUD as well. Copper IUDs seem to have a slightly lower expulsion rate than hormonal IUDs. (See “Levonorgestrel vs copper

IUD expulsion rates after immediate postpartum insertion.”) This consideration should be talked about ahead of time, too. Provider training in IUD placement does impact the likelihood of expulsion, and if you place the IUD at the fundus, it is less likely to expel. (See “Inserting the immediate postpartum IUD after vaginal and cesarean birth step by step.”)

A third issue that clinicians run into is actually the systems of care—making sure that the IUD or implant is available when you need it, making sure that documentation happens the way it should, and ensuring that the follow-up billing and revenue cycle happens so that the woman gets the device that she wants and the providers get paid for having provided it. These issues require a multidisciplinary team to work through in order to ensure that postpartum LARC placement is a sustainable process in the long run.

Often, when people think of immediate

postpartum LARC they think of postplacental IUDs. However, an implant also is an option, and that too is immediate postpartum LARC. Placing an implant is often a lot easier to do after the birth than placing an IUD. As clinicians work toward bringing an immediate postpartum LARC program to their hospital system, starting with implants is a smart thing to do because clinicians do not have to learn or teach new clinical skills. Because of that, immediate postpartum implants are a good troubleshooting mechanism for

opening up the conversation about immediate postpartum LARC at your institution.

OBG MANAGEMENT: What advice do you have for administrators or physicians looking to implement an immediate postpartum LARC program into a hospital setting?

Dr. Hofler: Probably the best single resource is the American College of Obstetricians and Gynecologists' Postpartum Contraception Access Initiative (PCAI). They have a

Inserting the immediate postpartum IUD after vaginal or cesarean birth step by step

Technique for placing an IUD immediately after vaginal birth

1. Bring supplies for intrauterine device (IUD) insertion: the IUD, posterior blade of a speculum or retractor for posterior vagina, ring forceps, curved Kelly placenta forceps, and scissors.
2. Determine that the patient still wants the IUD and is still medically eligible for the IUD. Place the IUD as soon as possible following placenta delivery; in most studies IUD placement occurred within 10 minutes of the placenta. Any perineal lacerations should be repaired after IUD placement.
3. Break down the bed to facilitate placement. If the perineum or vagina is soiled with stool or meconium then consider povidone-iodine prep.
4. Place the posterior blade of the speculum into the vagina and grasp the anterior cervix with the ring forceps.
5. Set up the IUD for insertion: Change into new sterile gloves. Remove the IUD from the inserter. For levonorgestrel IUDs, cut the strings so that the length of the IUD and strings together is approximately 10 to 12 cm; copper IUDs do not need strings trimmed. Hold one arm of the IUD with the long Kelly placenta forceps so that the stem of the IUD is approximately parallel to the shaft of the forceps.
6. Insert the IUD: Guide the IUD into the lower uterine segment with the left hand on the cervix ring forceps and the right hand on the IUD forceps. After passing the IUD through the cervix, move the left hand to the abdomen and press the fundus posterior and caudad to straighten the endometrial canal and to feel the IUD at the fundus. With the right hand, guide the IUD to the fundus; this often entails dropping the hand significantly and guiding the IUD much more anteriorly than first expected.

7. Release the IUD with forceps wide open, sweeping the forceps to one side to avoid pulling the IUD out with the forceps.
8. Consider use of ultrasound guidance and ultrasound verification of fundal location, especially when first performing postplacental IUD placements.

Troubleshooting tips:

- If you are unable to visualize the anterior cervix, try to place the ring forceps by palpation.
- If you are unable to grasp the cervix with ring forceps by palpation, you may try to place the IUD manually. Hold the IUD between the first and second fingers of the right hand and place the IUD at the fundus. Release the IUD with the fingers wide open and remove the hand without removing the IUD.

Technique for placing an IUD immediately after cesarean birth

1. Determine that the patient still wants the IUD and is still medically eligible for the IUD. Place the IUD as soon as possible following placenta delivery; in most studies IUD placement occurred within 10 minutes of the placenta.
2. For levonorgestrel IUDs: Remove the IUD from the inserter. Cut the strings so that the length of the IUD and strings together is approximately 10 to 12 cm. Place the IUD at the fundus with a ring forceps and tuck the strings toward the cervix. It is not necessary to open the cervix or to place the strings through the cervix.
3. For copper IUDs: String trimming is not necessary. Place the IUD at the fundus with the IUD inserter or a ring forceps and tuck the strings toward the cervix. It is not necessary to open the cervix or to place the strings through the cervix.
4. Repair the hysterotomy as usual.

dedicated website (<https://pcainitiative.acog.org/>) and offer a lot of support and resources that include site-specific training at the hospital or the institution; clinician training on implants and IUDs; and administrator training on some of the systems of care, the billing process, the stocking process, and pharmacy education. They also provide information on all the things that should be included beyond the clinical aspects. I strongly recommend looking at what they offer.

Also, because many hospitals say, “We love this idea. We would support imme-

diate postpartum LARC, we just want to make sure we get paid,” the ACOG LARC Program website (<https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC-Medicaid-Reimbursement>) includes state-specific guidance for how Medicaid pays for LARC devices. There is state-specific guidance about how the device payment can be separated from the global payment for delivery—specific things for each institution to do to get reimbursed. ●

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