referrals per year for failed insertion or removal, or a history of severe pain and/or vasovagal syncope (VVS). Women referred are motivated to persevere with this method despite a bad experience. There are no data to indicate how many women are put off by a poor experience and rule out this method of contraception and/or menstrual control. In my experience, concerns around the fitting are the main barrier to improving the overall low uptake of intrauterine methods in the UK. I would strongly echo the consensus that the setting, confidence and technique of the provider, and particularly the presence of an assistant skilled at addressing anxiety, are key to the overall experience.

There are six points where I differ from Bahamondes *et al.*'s recommended practice.

- 1 I am fortunate to have an electric lithotomy couch but rarely use the leg supports, usually only where access to the cervix is particularly difficult. My preferred position is sitting on a stool with wheels at the side of the couch rather than with the woman at the end of the couch. Importantly the bed is elevated enough that my legs fit in under the couch so the cervix is comfortably at eye level.
- 2 The consensus view was that a tenaculum should always be applied. I avoid this painful stimulus if fitting is possible using gel alone. A tenaculum is essential for GyneFix®. However, with framed devices it is often unnecessary and will only increase pain. Admittedly I have the benefit of a scanner at the bedside and routinely check the position of any IUD. Accurate fundal placement and minimising the risk of perforation depend on good technique but this need not include use of a tenaculum in many cases.
- 3 I disagree with the authors' recommended toothed tenaculum pictured in their Figure 1. Although rarely reported,² I have seen several cases with an IUD thread exiting the cervix through a fistula, and one case where an intrauterine system reservoir was visibly protruding from a fistula with the thread running back into the fistula and out

Comment on 'Practical advice for avoidance of pain associated with insertion of intrauterine contraceptives'

Congratulations are due to the authors for producing much-needed guidelines.¹ These are necessarily a consensus owing to the lack of quality studies on pharmacological interventions. Since 2009 I have provided a referral service for intrauterine device (IUD) problems, and currently manage 400–500

of the os. It is possible a fistulous tract may be created where tenaculum teeth penetrated the cervix with the threads then finding their way into the tract before it heals. I would recommend use of less traumatic forceps such as Judd-Allis or Littlewood.

- 4 I endorse the superiority of tapered (e.g. Bonney Barker type) dilators over shouldered (Hegar type) dilators, but more than this there is a technique for finding the path of least resistance. Careful bimanual examination establishing the position of the fundus relative to the cervix does not allow the inserter to judge the exact direction to angle the dilator when they meet resistance. Straightening the cervico-isthmic junction with traction on the cervix can sometimes be helpful. However gently manipulating a dilator through 360° and sometimes changing the angle quite acutely may find a path with almost no resistance. This is much easier with a scanner at the bedside and a uterus that is sufficiently anteverted for simultaneous ultrasound guidance. Through use of simultaneous ultrasound guidance I have noted that suprapubic pressure can sometimes relax the internal os. On occasions when I have left the sound at the point of resistance while helping the assistant focus the image on the endocervical-endometrial canal we have noted the sound suddenly 'fall into' the cavity. I have not tried a suprapubic warming pack but presume that this is likely to have the same or better effect.
- 5 The os finder is good for stenosis of the external os. I would not recommend its use to overcome stenosis (or spasm) of the internal os. A tapered metal dilator would be my instrument of choice as it enables one to find a path of least resistance when the dilator is gently rotated and angulated at the point of resistance. One cannot do this with the os finder as it is too flexible and too sharp.
- 6 The authors recommend an intracervical block for difficult sounding. Cochrane Reviews conclude there is inadequate evidence of benefit with local anaesthetic. However, data

available on abortion under local anaesthetic supports that deep paracervical injection combined with a relatively high concentration of intrauterine lidocaine infusion improves pain scores.³ So my own practice where injection is needed is to insert a paracervical block. My understanding of the difference between intracervical and paracervical block is that with the former the needle is introduced through the cervical os and with the latter the needle is introduced a distance of 1–2 cm lateral to the os, which enables placement of the block at a higher level. I would strongly discourage use of a syringe with a 21 gauge needle, not only because it does not fit down the speculum leaving room for visualisation but because the needle size is too large for comfort. Use of a dental syringe with a long 27 gauge needle is superior. Although one cannot exclude vascular injection by checking for backflow, in practice a slight resistance with injection should confirm placement within tissue.

A recurring proportion of referrals are women who have had an IUD removed followed by failed reinsertion. This supports the impression that reflex closure of the internal os may be triggered by the stimulus of removing a device. Personally I have found the technique of slow filling the cavity with local anaesthetic gel, avoiding overfilling by asking the woman to say as soon as any sensation of cramping starts, and waiting several minutes together with care to avoid any sudden or sharp stimulus on removal of the old device avoids this problem. A criticism of this technique is that there is a lack of evidence. However, studies on topical gel have generally not considered the difference between endometrial and endocervical absorption nor the importance that 3 minutes or less may be unrealistically short for topical absorption. Evidence to support this practice lies in the success of managing 99% of referrals with one or more previous failed procedures in a 30-minute one-stop outpatient appointment, and a VVS rate of less than 0.2% (two cases in over 4 years, neither requiring medication) despite high-risk referrals, a number of whom had experienced

severe VVS at a previous procedure. It is my personal view that a painful stimulus is likely to be the most important cause of VVS.

Mary Pillai, FRCOG, MRCPC

Consultant in Community Gynaecology and Obstetrics, Gloucestershire Care Services NHS Trust – Sexual Health Service, Gloucestershire Royal Hospital, Gloucester, UK; Mary.Pillai@glos.nhs.uk

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