Difficult IUD insertions

I read with interest Dr Isabel Draper’s letter regarding difficult intrauterine device (IUD) insertions published in the January 2008 issue of this Journal. I agree with Dr Draper’s views and would like to share my experience on this subject.

I am an instructing doctor and do two IUD/intrauterine system (IUS) training clinics every week. One training clinic is at The Palatine Centre in Manchester and the other is a Gynaecology Tier 2 clinic in Stockport with facilities for on-site ultrasound scanning for difficult IUD/IUS insertions/removals. On an average five patients are seen in each clinic for IUD/IUS insertions.

Nearly 30% of patients I see are under the age of 25 years and nulliparous. In my experience I have found that insertion of TT380 Slimline®, TCu380®, QuickLoad® or T-Safe 380A®, which are current recommended gold standards, can be at times difficult and painful to insert in this group of patients. I agree with the author’s comments that insertion of the IUS can also be challenging in this group of women.

I find the following methods helpful in reducing the discomfort associated with IUD/IUS insertions.

1. Injection of local anesthetic directly into the cervix (intracervical block) at the 3, 6, 9 and 12 o’clock position is very effective. A 27-gauge dental syringe is used to inject 3% Mepivacaine (Scand Jensen®) or Articaine® with adrenaline (Septanal®), which is available in cartridges. In order to divert the women’s attention I usually ask the patient to cough at the time of injection.

2. Anesthetic gel such as Instillagel® (lidocaine 2% and chlorhexidine gluconate solution 0.2% w/v) used with Instillaquill® applied on the ectocervix and directly into the endocervical canal takes up to 5 minutes to work. Therefore I rely on its lubricant properties in enhancing ease of insertion.

3. Topical application of lidocaine ointment (5%) on the ectocervix.

There is a lack of randomised controlled trials investigating the use of topical or intracervical anaesthesia during IUD/IUS insertions.

Methods used to aid clinicians in dilating the cervical os if resistance is encountered are listed below.

1. A plastic disposable graduated uterine sound and dilator is available from Durbin Sales. Dilatation up to 5.5 mm can be achieved with this disposable plastic instrument that has a graduated cervical dilator at one end and a sound at the other end. It is marked at 1 cm intervals, and the dilator end is tapered with gradual increase in width to 5.5 mm and has a gentle curve. In my experience it is easy to use compared to the metal Hegars dilators.

2. Vaginal use of misoprostol (200 μg) inserted 3 hours prior to IUD/IUS insertion softens the cervix. This may cause some vaginal bleeding and cramps, and due to the risk of tenacitogenicity should be used during a period or a reliable method of contraception should be advised during that cycle. Previous Caesarean section is a risk factor for perforation.2 Risk of perforation is directly proportional to the degree of difficulty encountered during the insertion, clinician’s experience and technique.

I can foresee that these potential difficult cases will be referred to specialist clinics or will be done by experienced practitioners. I share Dr Draper’s concerns about trainees who would have to learn in this environment and the need for post-residency sessions to enable them to achieve adequate skills.

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References

Reply

I agree with Dr Navani that the plastic disposable sound and dilator seems more satisfactory than traditional metal dilators. A technique I use with Instillagel® that seems to make this method of local anesthetic more effective is to keep the speculum in place for the 5 minutes after applying it (with due apologies to the woman for the indignity!) so the cervix is bathed in the gel that pools in the jaws of the speculum. I was interested to read of the use of misoprostol in this situation, which I was not aware of.

Some innovative ideas have obviously evolved in response to this problem. Perhaps a future article for the journal could be a summary of these, seeing as I am obviously not alone in experiencing the problem.

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Removal of copper-bearing IUDs in asymptomatic patients

We read with interest the case report regarding the migration of an intrauterine device (IUD) in an asymptomatic woman post-insertion.1 We have also recently had a case of IUD migration in an asymptomatic patient. She had a copper-bearing IUD inserted 10 weeks after normal vaginal delivery that was uncomplicated. The patient had been fully counselled regarding contraceptive choices, and was still breastfeeding at this time. As per the World Health Organization Medical Eligibility Criteria for Contraceptive Use (WHOMEC), the IUD was inserted more than 4 weeks postpartum.2

A review appointment 2 months later found that the strings of the IUD were absent. A pelvic ultrasound demonstrated that the IUD was no longer in the cavity. She was reviewed again 6 weeks later, and was easily retrieved via the laparoscopic approach in asymptomatic patients pending ultrasound confirmation that the IUD was no longer in the cavity. She was reviewed again 6 weeks postpartum with no issues.

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We believe that the potential of complicated sequelae arising from the presence of a copper-bearing IUD outweigh the benefits of a conservative approach. Minimally invasive methods to remove translocated IUDs are becoming the mainstay approach, with alternatives for locating the IUD that is not easily visualised in order to reduce conversion to laparotomy, thus decreasing patient morbidity.3 Extraterine IUDs should therefore be removed even in the asymptomatic patient.

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Figures 1 and 2 The intrauterine device is cased in the cervix (intracervical block) at the 3, 6, 9 and 12 o’clock position.

Figure 3 Removal of the intrauterine device using a laparoscopic approach.
Letters to the editor

References

Reply
We welcome the response by Lee et al., which is a valuable contribution towards the management of translocated intrauterine devices (IUDs).

Lee et al. referred to the series of three cases described by Markovitch et al. These patients did not develop any complications resulting from the translocated IUD. Markovitch et al. clearly describe the circumstances under which conservative management of translocated IUDs is possible and also express the need for additional study on this topic.

The WHO3 and Faculty of Sexual and Reproductive Healthcare4 guidelines recommend removing the IUD, particularly the copper ones, as soon as is reasonably possible. The problem with not following these guidelines is the unpredictability of the migration of the IUD and the associated outcome.

Lee et al. describe a case history of a patient using a Copper-7® IUD who remained asymptomatic for 2 years despite the device being translocated to the sigmoid colon without any evidence of intra-abdominal adhesions or sepsis.

The remote possibility of catastrophic events cannot be ruled out. Robinson6 describes an asymptomatic patient at serious risk from catastrophic rupture of the superior mesenteric artery by a translocated Copper-7 device. Avni et al.7 studied the peritoneal reaction to copper devices in female albino rats. They found that the copper device group developed severe adhesions and consequently they recommended removal to minimise the harmful effects of copper. It is unclear to what extent these findings can be applied to humans.

In the absence of a tool to assess the risk, we recommend adhering to the WHO and Faculty of Family Planning guidelines.

We would welcome further discussion of this topic.

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References

Training for the LoC IUT
I read Dr Siddiqui’s letter1 in the January 2008 issue of the Journal with great interest. I agree that the associated outcome.

Dr Siddiqui does not seem to have understood my point. I was not saying that we should not fit copper intrauterine devices (IUDs) and I am happy to do so if women request them. My point, which Dr Siddiqui accepts, was that most general practitioners (GPs) will only fit the intrauterine system (IUS) (Mirena®) and if we insist that they must fit a copper IUD to obtain their Letter of Competence (LoC) then most of them will not be able to train. Most general hospitals do not have the facility to do all IUD fitting and many family planning clinics are under threat. We do need GPs to fit IUDs, both for contraception and also for the treatment of menorrhagia. If we do not allow them to obtain the LoC then they will stop fitting IUDs/IUS. This will not benefit patients. It is difficult for doctors who wish to train to obtain the necessary experience; we do not need to make it more difficult.

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References

Localisation of non-palpable implants
I read the article by Mansour et al.1 on methods of accurate localisation of non-palpable subdermal implants in the January 2008 issue of the Journal with great interest. I agree that alongside my own growing experience of implant localisation were highlighted in this article. I read Dr Siddiqui’s letter in the January 2008 issue of the Journal with great interest. I agree that the associated outcome.

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Reference

Implanon insertion in Zimbabwe
Recently in a family planning session, a 52-year-old Zimbabwean female presented for an Implanon® removal. The patient was insisted that she had had Implanon inserted and that the procedure had involved two rods and that she had been advised that this would last for 5 years. On palpation, two rods could be felt in different planes in the left upper arm but it was difficult to discern whether these were one rod divided in two or two separate rods. On removal, they were found to be two separate intact Implanon devices.

On further enquiry from the patient, we were advised that it was common practice for two rods to be inserted at a medical practice in Zimbabwe, and that patients had been advised that duration was 5 years. The patient had not experienced any adverse effects and had decided to have the Implanon removed so that she could become pregnant.

It would be interesting to know whether the above is a true representation of Implanon insertion in Zimbabwe and, if so, whether this is an indication of training needs or whether there appears to be a misconception that two rods must in combination provide greater contraceptive cover than one rod previously available (Norplant®).

We would be grateful for any feedback from readers.

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