LETTERS TO THE EDITOR

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

I fully endorse reducing anxiety, ‘verbal anaesthesia’, the skill of the health care provider (HCP) and having a ‘chatty’ assistant present: these are essential but not always sufficient. As the Bahamondes et al.¹ review states, around 17% of nulliparous and 11% of parous women report pain that is ‘severe’. If given freedom to say so, a further group of women reports pretty nasty discomfort. In our own study² 38% of subjects reported their insertion pain as very or moderately distressing, whereas their doctor reported it as ‘mild’ or ‘minimal’!

Picture the scene, repeated intermittently anywhere that intrauterine contraceptives (IUCs) are inserted. The client is relaxed, appears an ideal candidate, the right ambience and skills are all there. Yet, the moment holding forceps are applied (whatever the design, it is a myth that Judd-Allis tenaculums are especially benign), she yelps with pain. Importantly, for this minority of women, this sharp somatic pain seems then to worsen the whole experience including later (cramping) pains.

The authors quoting a Cochrane Review³ say that “pharmacological strategies” fail to show “clear evidence that pain is significantly reduced during or after routine IUC placement”. Yet two double-blind randomised studies² ⁴ were not evaluated, totalling 190 women. With tolfenamic acid 200 mg three times a day started post-insertion, significantly reduced (p<0.01) spasmodic pain was reported in the subsequent 24 hours⁴; and measured by visual analogue scales (VAS), there was significant post-insertion pain reduction at 10 minutes with mefenamic acid 500 mg given 60 minutes pre-insertion.² Moreover, the “absence of proof” from other good studies cited in the Cochrane Review³ cannot be “proof of absence” of benefit by non-steroidal anti-inflammatory drugs (NSAIDS) for prostaglandin-related pain.
For the unpredictably severe tenaculum pain, the problem is wide individual variation; and neither study\(^2\)\(^4\) demonstrated benefit by NSAIDs. What about local anaesthesia? This has indeed only been evaluated for other gynaecological procedures. But so what, if that well-defined pain is produced identically? Robinson \textit{et al.}\(^5\) reported in a double-blind randomised controlled trial that hysterosalpingography subjects receiving a 1% lidocaine cervical block totalling 6 ml had significantly less pain \((p<0.001)\) measured by VAS from tenaculum placement, compared with a placebo intracervical saline injection group and a no-injection group. Another single-blind study, admittedly too recent for Bahamondes \textit{et al.} to cite, randomised 74 women. Those receiving 2 ml 1% lidocaine at the 12 o’clock position had lower mean pain levels by VAS at tenaculum placement \((p<0.001)\) than the controls receiving 2% lidocaine gel topically.\(^6\)

Anaesthetists maintain it is more effective to pre-empt most pains than to try to remove them when present, and lower total anaesthetic doses are required. My teaching pending more data – based on available literature, clinical experience and a desire to give the woman the benefit of the doubt about how much pain she will have – is that premedication with an NSAID of the HCP’s choice about 40 minutes beforehand should be routinely offered to everyone: unless rejected or contraindicated. Everyone should also be offered a 1 ml dose of plain lidocaine 1% or prilocaine 4%, injected at 12 o’clock slowly through the finest available needle, 1–2 minutes ahead of the tenaculum. This reliably prevents the tenaculum causing pain. Women are of course welcome to reject this offer too, but one group never does so: those women who have previously experienced severe tenaculum pain, who also find the 1 ml injection negligibly painful in comparison. (NB. Full cervical anaesthesia is quite different, reserved for the cases described in the Bahamondes \textit{et al.} review.)

Finally, to minimise pain at IUC insertion there is a much-overlooked opportunity with many other advantages, namely just after surgical termination of pregnancy: given the already-present local or general anaesthesia. Misgivings about expulsion rates and infections are without foundation.\(^7\)

This should be the norm, with of course full counselling well beforehand and, again, easy opt-out.

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\textbf{REFERENCES}


