Congratulations are due to the authors for producing much-needed guidelines. 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 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 GynFix®. 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, 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...
Letters to the editor

of the os. It is possible a fistulous tract may be created where tenacu-

lum teeth penetrated the cervix with the threads then finding their way

into the tract before it heals. I would recommend use of less traumatic

forces 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 chang-

ing 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 suf-

ciently 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-endomet-

rial 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 recom-

mend 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.1 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 place-

ment 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 trig-

gered by the stimulus of removing a device. Personally I have found the

technique of slow filling the cavity with local anaesthetic gel, avoiding overfill-

ing 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 evi-

dence. However, studies on topical gel

have generally not considered the dif-

ference between endometrial and endocervical absorption nor the importance

that 3 minutes or less may be unrealis-

tically short for topical absorption.

Evidence to support this practice lies in the success of managing 99% of refer-

rals 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 medica-

tion) 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 im-

portant cause of VVS.

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