

## **Boston Medical Center Maternity Care Guideline**

### **Guideline: Immediate Postpartum LARC Counseling and Insertion**

**Accepted: 3/13/19**

**Updated: 3/08/19**

#### **Purpose**

To provide clinicians with evidence-based information to make decisions in partnership with women about immediate postpartum long-acting reversible contraception.

#### **Definition**

*Immediate postpartum (IPP)*: placement of a device during the inpatient postpartum stay

*Long-acting reversible contraception (LARC)*: intrauterine devices and contraceptive implants

*Post-placental insertion*: placement of a device while in the delivery room

*Immediate post-placental*: placement of a device within 10 minutes of delivery of the placenta during a vaginal or cesarean delivery

#### **Background**

Nearly one half of all pregnancies in the United States are unintended. Many barriers exist that contribute to this pregnancy rate, notably the difficulty in obtaining effective birth control in the postpartum period. In addition to prenatally, it is at the six-week postpartum visit where women receive birth control counseling. Unfortunately, many women do not present to their follow up visits and do not receive contraceptive counseling. Additionally, many women have become sexually active by their follow-up visit, and if they are not exclusively breastfeeding, may become pregnant.

Multiple studies attest to the safety, efficacy, and cost-effectiveness of immediate postpartum IUD and implant placement (1-3). The Centers for Disease Control and Prevention's 2010 U.S. Medical Eligibility Criteria for Contraceptive Use (MEC) has been endorsed by ACOG and provides guidance about the safety of postpartum contraceptive use. Immediate postpartum initiation of IUDs and implants are classified as Category 1 (no restriction for use) or Category 2 (advantages generally outweigh theoretical or proven risks) (4).

#### **Procedures**

Prenatal care providers should counsel all pregnant patients by 32 weeks gestation on all contraceptive options for which the woman is eligible. If she desires a LARC method, raise the possibility of in-hospital placement. The available devices for immediate postpartum placement are Liletta, Skyla, Paragard, and Nexplanon.

Counseling should include a discussion of the overall risks and benefits of LARC devices (including the possible changes in bleeding patterns), as well as the particular risks and benefits of in-hospital placement.

Benefits specific to immediate postpartum IUD placement include:

- Convenient setting for placement of IUD
- Less patient discomfort
- No need for a return visit for device insertion
- No increased risk of bleeding or infection postpartum
- Verification that the patient is not pregnant

Risks specific to immediate postpartum placement include:

- Higher expulsion rate (possibly as high as 27%, as compared to 5-10% for outpatient placement)
- May need to trim strings postpartum
- Missing strings common (see **Follow Up**)
- Risk of inability to place because of labor and delivery complications

Contraindications to immediate postpartum IUD placement include:

- Chorioamnionitis
  - Fever and symptoms of intrauterine infection that necessitate antibiotic treatment)
- Acute hemorrhage at the time of delivery
  - QBL>1000 cc and/or continued bleeding
- Routine contraindications to IUD placement
  - Untreated infection with gonorrhea or chlamydia or no test of cure
  - Uterine malformation
  - Fibroids causing distortion of the uterus
  - Cervical cancer
  - Pelvic tuberculosis
  - AIDS and clinically unwell on ARVs (due to risk of pelvic infections)
  - Malignant or benign trophoblastic disease
  - Severe anemia (for the copper IUD)
  - Wilson's disease (for the copper IUD)
  - Breast cancer (for the levonorgestrel IUD)
  - Systemic lupus with positive or unknown antibodies (for the levonorgestrel IUD)

Breastfeeding and postpartum LARC devices:

- All LARC devices are safe to use during breastfeeding
- Research has shown that for moms who use the implant or IUD, there is no difference in:
  - a woman's ability to successfully initiate and continue breastfeeding
  - the amount of milk she produces
  - the amount of newborn milk intake
  - an infant's growth and development
- In terms of CDC recommendations, the implant is considered a Category 2 (benefits outweigh risks), the same as the progestin-only pill and Depo-Provera.

## Timing of Counseling

While the goal of antenatal contraceptive counseling is to have the discussion at or prior to 32 weeks gestation, the discussion of IPP LARC may take place any time prior to admission in labor or for delivery. At the time of hospital admission for delivery, if the patient hadn't been previously counseled about the option of IPP LARC, she should NOT be counseled while she is in labor or still pregnant, to avoid the possibility of coercion. The provider team may consider LARC counseling on postpartum day 1.

If the woman is interested in IPP LARC, inform her that placement is dependent on her insurance coverage at the time of delivery; current coverage can be verified with the clinic staff (front desk or medical assistant).

## Documentation

Regardless of method choice, contraceptive counseling and plan should be added to the Epic Problem List: Supervision of Pregnancy, under "Contraception." If IPP LARC is discussed, use the dot phrase .BMCBPPLARC.

Patient desire for IPP LARC placement should be indicated on the problem list:

- Use the diagnosis Counseling for initiation of birth control method (V25.02, Z30.09)
- Click "Details"
- Under "Display," write DESIRES PP IUD or DESIRES PP NEXPLANON

An appropriate IUD or implant consent form should be completed prior to the patient presenting in labor. Blank consent forms can be found in two places:

1. On Sharepoint Obstetrics and Gynecology:
  - a. Consents OB and GYN →
  - b. BLANK CONSENT FORMS →
  - c. Family Planning Consents
2. On the Boston University website:
  - a. <http://www.bumc.bu.edu/obgyn/>, password bmcobgyn
  - b. Resources and Guidelines in the menu bar →
  - c. Departmental Resources →
  - d. Patient Consents [OB English]
  - e. Direct link: <http://www.bumc.bu.edu/obgyn/ob-english-consents/>

The completed consent forms should be faxed to 617-507-6119. A scanned copy of the form will be placed into the consent folder on Sharepoint under "Consent forms OB and GYN→ Postpartum LARC." In addition provide a copy to the patient that she may present at time of admission. If the patient does not have her consent it may be printed and placed into the patient's chart at the time of admission.

## Follow Up

At a patient's six-week follow-up visit, confirm that the patient is satisfied with the IUD and does not desire removal. A string check should be performed as part of their routine postpartum

care to confirm IUD presence. This string check can be performed with a bimanual exam, if she has no complaints about the string length, or can be performed with a speculum exam, allowing for string trimming.

If no strings are palpable or seen and the patient does not report the expulsion of the IUD, ultrasound can be used to check for position.

- If the IUD is visible in the uterus, it may be left in place (even if the orientation of the IUD has shifted, or the IUD is in the lower uterine segment).
- If a portion of the IUD is visible in the cervix, the IUD should be removed and replaced. If unsure, consult Family Planning to review the ultrasound with you.
- If the IUD has been expelled, the patient can then be offered either replacement of the IUD or another form of birth control.

Counsel the patient that the IUD can be removed at any time. If she desires IUD removal in the future to try to conceive, counsel that the IUD can be removed once she is ready to become pregnant; it does not need to be removed months in advance (no “wash out period” needed).

## References

- (1) Garipey AM, Duffy JY, Xu X. Cost-effectiveness of immediate compared with delayed postpartum etonogestrel implant insertion. *Obstet Gynecol* 2015;126:47–55.
- (2) Washington CI, Jamshidi R, Thung SF, Nayeri UA, Caughey AB, Werner EF. Timing of postpartum intrauterine device placement: a cost-effectiveness analysis. *Fertil Steril* 2015;103:131–7.
- (3) Rodriguez MI, Caughey AB, Edelman A, Darney PD, Foster DG. Cost-benefit analysis of state- and hospital-funded postpartum intrauterine contraception at a university hospital for recent immigrants to the United States. *Contraception* 2010;81:304–8.
- (4) Update to CDC’s U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. Centers for Disease Control and Prevention (CDC). *MMWR Morb Mortal Wkly Rep* 2011;60:878–83.

## **Appendix. Dot phrases in the Epic electronic health record.**

### **.BMCOBPPLARC:**

Patient desires \*\*\*IUD/implant after delivery for contraception. Counseled about the risks and benefits of the device \*\*\*including the increased risk of IUD expulsion (up to 24%) and possible need for trimming of the strings. She is interested in in-hospital placement of the device if possible. Will confirm insurance coverage.

### **.BMCOBIMPLANT:**

Patient desires postpartum Nexplanon placement. A time out procedure was performed. The patient was placed in the proper positioning with her arm flexed behind her head. A marking pen was used to indicate the insertion location and guiding mark. The skin was cleaned with a cleansing solution. The 3cc lidocaine 1% \*\*\*with epi was injected at the insertion site and along the route of planned insertion. The Nexplanon was placed subdermally and was palpable following insertion. Good hemostasis was noted. The skin was closed with a \*\*\*steristrip/pressure dressing, and a pressure bandage was applied around the arm.

### **.BMCOBIUD:**

Patient desires immediate post-placental IUD. Following placental delivery, a speculum was placed in the vagina and the cervix cleaned with a cleansing solution. \*\*\*A ring forceps was placed on the anterior lip of the cervix for stabilization. Using ultrasound guidance, the \*\*\*[hormonal IUD inserter was][long forceps were] passed through the lower uterine segment and the IUD placed at the uterine fundus. \*\*\*The strings were trimmed at the external os. Ultrasound confirmed IUD in correct location. Good hemostasis. All instruments removed from the vagina.