Boston Medical Center Maternity Care Guideline

Guideline: Postpartum Contraception - Options & Safety

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Purpose

To provide clinicians with evidence-based information on postpartum contraception safety and to make enhance shared decision making with patients regarding these options.

Definitions

Centers for Disease Control and Prevention's 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (CDC MEC): national contraceptive safety guidelines

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

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

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

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

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. Following discussion prenatally, it is often at the six-week postpartum visit where women receive birth control counseling. Unfortunately, many women face barriers in presenting to their follow up visits and thus do not receive counseling and method initiation. Additionally, many women have already become sexually active by their follow-up visit, and if they are not exclusively breastfeeding, may become pregnant during this time. The immediate postpartum period represents an ideal window of time to discuss contraception with women before discharge from the hospital.

The goal of this document will be to review contraceptive options available to women in the immediate postpartum period and the notable contraindications and possible side effects of these methods during use in this period. We will refer to the Centers for Disease Control (CDC) and Prevention's 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (MEC). This resource has been endorsed by ACOG and provides guidance about the safety of postpartum contraceptive use. Discussion of possible lactation side effects are discussed separately from general safety information. Finally, this document will also detail information to use and relevant protocols in the immediate postpartum period.

Prenatal Care Considerations

Contraception Counseling

- Ideally complete counseling by 32 weeks' gestation.
- Discuss eligible methods (below) and engage in shared decision making for what option would be best for the patient. Please refer to each method's complete section for full information when counseling on this method.
- This document does not cover how to complete this prenatal counseling; Appendices B & C lists resources that may be helpful.
- Medical Eligibility: Please refer to WHO Medical Eligibility Criteria for any considerations specific to each patient's medical contraindications. (See Appendix D)

Intrauterine Devices (IUDs)

Overview

Ideally, use of postpartum IUDs should be discussed prenatally and include a conversation of possible in-hospital, immediate placement. The available devices for immediate postpartum placement are Liletta, Skyla (both contain levonorgestrel), and the Paragard (contains copper). Counseling should include a discussion of the overall risks and benefits of IUDs (including the possible changes in bleeding patterns), as well as the particular risks and benefits of in-hospital placement.

While the goal of antenatal contraceptive counseling is to have the discussion at or prior to 32 weeks' gestation, the discussion of IPP IUD use 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 IUD use, she should NOT be counseled while she is in labor or still pregnant, to avoid the possibility of coercion. The provider team may consider re-addressing this counseling on postpartum day 1.

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 (at ~10% but possibly as high as ~30%, as compared to ~2% 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

Safety and Contraindications to Immediate Use

- 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 including:
    - Untreated infection with gonorrhea or chlamydia or no test of cure
    - Uterine malformation
    - Fibroids causing significant 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)
    - Liver tumors (for the levonorgestrel IUD)
    - Systemic lupus with positive or unknown antibodies (for the levonorgestrel IUD)
- Regarding use in the postpartum period: Per the CDC MEC, both the hormonal and copper IUDs are rated based on timing placement given the concern for increased device expulsion:
    - Under 10 minutes postpartum: category 1 (no restrictions)
    - From 10 minutes to under 4 weeks postpartum: category 2 (benefits of use generally outweigh the theoretical or proven risks)
    - Over 4 weeks postpartum: category 1 (no restrictions)
- For use in the presence of other specific health conditions, please refer to CDC MEC.

Lactation Effects

- All IUDs are safe to use during breastfeeding
- Review of current evidence indicates that IUDs do not negatively impact a woman's ability to successfully initiate and continue breastfeeding. Evidence also indicates that IUDs do not appear to affect the infant's growth and development.
- Regarding use while breastfeeding: Per the CDC MEC, the copper IUD is rated as a category 1 (no restrictions) at all points of initiation. The hormonal IUDs are rated as a category 2 (benefits of use generally outweigh the theoretical or proven risks) until 4 weeks postpartum at which time they become a category 1 (no restrictions).

Other Information

On arrival to L&D:

If the patient does not have their copy of the IPP IUD consent form, please print from Sharepoint and place in the patient's chart on 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 any 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).

Appendix Information:

- Appendix A: Includes a dot phrase for use prenatally at the time of original counseling of PP IUD placement and a dot phrase for documenting the IUD insertion procedure.
- Appendix B & C: Includes links to resources on the insertion process of an immediate post placental IUD.

The Implant

Overview

Ideally, use of the implant should be discussed prenatally and include a conversation of possible in-hospital placement. If discussed, it is helpful for the provider to indicate in the supervision of normal pregnancy problem if the patient would like placement before discharge from her delivery admission or at the 6-week postpartum visit. If not discussed prenatally, this can also be discussed once the mother is on the postpartum unit before she is discharged.

Safety and Contraindications to Immediate Use

- Overall, there are no specific safety or contraindications to use of the implant in the immediate postpartum period outside of breastfeeding concerns (discussed below)
- Routine contraindications to implant placement include:

    - Breast cancer
    - Significant liver disease or liver cancer
    - Allergy to device components
- Regarding general use in the postpartum period: Per the CDC MEC, implants are rated a category 1 (no restrictions) for use at any time.
- For use in the presence of other specific health conditions, please refer to CDC MEC.

Lactation Effects

- The implant is safe to use during breastfeeding
- Review of current evidence indicates that the implant does not negatively impact a woman's ability to successfully initiate and continue breastfeeding. Evidence also indicates that the implant does not appear to affect the infant's growth and development.
- Regarding use while breastfeeding: Per the CDC MEC, implant use is rated depending on its initiation timing. Implants are rated as a category 2 (benefits of use generally outweigh the theoretical or proven risks) until 4 weeks postpartum at which time they become a category 1 (no restrictions).

Other Information

- On arrival to L&D:
    - If the patient does not have their copy of the IPP implant consent form, please print from Sharepoint and place in the patient's chart on admission. If not completed, this can also be done on postpartum day 1.
- Postpartum placement:
    - The implant can be placed at any time prior to hospital discharge. Only trainers who have received formal training in Nexplanon insertion should place postpartum implants.
- Follow Up:
    - No follow-up is required after placement of immediate postpartum implant.
- Appendix Information:
    - Appendix A: Includes a dot phrase for use prenatally at the time of original counseling of PP implant placement and a dot phrase for documenting the implant insertion procedure.

Depo-Provera

Overview

Depo-Provera is safe to use in the postpartum period with no significant medical or procedural considerations in the immediate postpartum period compared to other times of use. Ideally, use of Depo-Provera should be discussed prenatally and include a conversation of possible in-hospital injection. If not discussed prenatally, this can also be discussed once the mother is on postpartum before she is discharged.

Safety and Contraindications to Immediate Use

- Overall, there are no specific safety or contraindications to use of Depo-Provera in the immediate postpartum period outside of breastfeeding concerns (discussed below)
- Routine contraindications to Depo-Provera use include:
    - Breast cancer
    - Significant liver disease or liver cancer
    - Poorly controlled hypertension
    - Undiagnosed vaginal bleeding
    - Advanced diabetes (evidence of end-organ damage and/or duration over 20 years)
    - Systemic lupus erythematosus with positive or unknown antibodies
    - Prior allergic reaction to Depo-Provera
- Regarding general use in the postpartum period: Per the CDC MEC, Depo-Provera is rated a category 1 (no restrictions) for use at any time.
- For use in the presence of other specific health conditions, please refer to CDC MEC.

Lactation Effects

- Depo-Provera is safe to use during breastfeeding
- Review of current evidence indicates that overall, Depo-Provera does not negatively impact a woman's ability to successfully initiate and continue breastfeeding. Evidence also indicates that Depo-Provera does not appear to affect the infant's growth and development.
- Regarding use while breastfeeding: Per the CDC MEC, Depo-Provera use is rated depending on its initiation timing. Depo-Provera is rated as a category 2 (benefits of use generally outweigh the theoretical or proven risks) until 4 weeks postpartum at which point they become a category 1 (no restrictions).

Other Information

- Postpartum: Please refer to the smart phrase as found in the L&D discharge summary dot phrase for documentation on postpartum depo

Progestin Only Pills (POPs)

Overview

Progestin-only pills (POPs) are safe to use in the postpartum period with no significant medical or procedural considerations in the immediate postpartum period compared to other times of use.

Safety and Contraindications to Immediate Use

- Overall, there are no specific safety or contraindications to use of POPs in the immediate postpartum period outside of breastfeeding concerns (discussed below)
- Routine contraindications to progestin-only pill use include:
    - Breast cancer
    - Significant liver disease or liver cancer
    - Ischemic heart disease

    - Systemic lupus erythematosus with positive or unknown antibodies
    - Use of select anticonvulsants (reduces method efficacy)
    - Use of rifampin (reduces method efficacy)
- Regarding general use in the postpartum period: Per the CDC MEC, POPs are rated a category 1 (no restrictions) for use at any time.
- For use in the presence of other specific health conditions, please refer to CDC MEC.

Lactation Effects

- POPs are safe to use during breastfeeding
- Review of current evidence indicates that progestin-only pills do not negatively impact a woman's ability to successfully initiate and continue breastfeeding. Evidence also indicates that they do not appear to affect the infant's growth and development.
- Regarding use while breastfeeding: Per the CDC MEC, progestin-only pill use is rated depending on its initiation timing. POPs are rated as a category 2 (benefits of use generally outweigh the theoretical or proven risks) until 4 weeks postpartum at which point, they become a category 1 (no restrictions).

Estrogen-Containing Methods

Overview

Estrogen containing methods are also known as combination hormonal contraception (CHCs) and include oral pills, the patch and the vaginal ring. Unlike many of the previously discussed methods, CHCs have a number of important medical contraindications based on the time they are used in the postpartum period that providers should be aware of.

Safety and Contraindications to Immediate Use

- Estrogen-containing medications are known to increase a patient's risk for possible VTE. Additionally, women are also at an increased risk for possible VTE while in the postpartum period, with the highest risk in the first 3 weeks from delivery. Taken together, these factors combine to create an unacceptably high risk of VTE for any patient regardless of risk factors. Therefore, providers are generally advised to avoid prescription of CHCs in the first 6-weeks postpartum to mitigate these risks.
- Routine contraindications to oral combination pill use:
    - Breast cancer
    - Migraines with aura
    - Chronic hypertension and/or poorly controlled hypertension
    - Significant cardiovascular and/or valvular disease
    - Significant liver disease or liver cancer
    - Use of select anticonvulsants (reduces method efficacy)
    - Use of rifampin (reduces method efficacy)
    - Advanced diabetes (evidence of end-organ damage and/or duration over 20 years)
    - Age over 35 with tobacco use

    - History of VTE (DVT, PE, stroke) or known thrombophilia or other high-risk factors for VTE occurrence (such as major surgery with prolonged immobilization)
    - Systemic lupus erythematosus with positive or unknown antibodies
- Regarding general use in the postpartum period, the CDC MEC gives different recommendations based on time from delivery, predominantly based on VTE risk.
    - Less than 3 weeks postpartum: category 4
    - From 3 weeks through 6 weeks postpartum: category 2-3 depending on presence or absence of high-risk features for development of VTE. These high-risk factors include history of VTE, elevated BMI, PPH, cesarean delivery, pre-eclampsia, smoking, age over 35, thrombophilia, immobility, transfusion requirement during delivery, peripartum cardiomyopathy.
    - Over 6 weeks postpartum: category 1
- For use in the presence of other specific health conditions, please refer to CDC MEC.

Lactation Effects

- CHCs have some important breastfeeding safety considerations depending on how far the patient is in their postpartum course.
- Less than 3 weeks postpartum: CHCs are discouraged during this timeframe due to unacceptably high risk of VTE. Still, review of the current breastfeeding evidence paints a mixed picture. Also, it is worth noting that studies have only examined the effect of oral pills, not the patch or the ring. Some studies show no effects from oral pill use while others demonstrate decreased exclusivity and/or duration of breastfeeding when used. During this time, the CDC MEC rates use of CHCs while breastfeeding as category 4.
- From 3 weeks through 6 weeks postpartum: Examining only from a breastfeeding safety perspective, the data remains mixed, with some concerns for exclusivity and/or duration decreases with use of oral combination pills. Within this window, the CDC MEC gives two category recommendations based on timing. If under 30 days postpartum, CHCs are rated as a category 3 and when over 30 days postpartum, they are rated as a category 2.
- Over 6 weeks postpartum: Examining only from a breastfeeding safety perspective, the data remains mixed with the same above-mentioned concerns on exclusivity and/or duration decreases. During this time, the CDC MEC rates use of CHCs for breastfeeding women as category 2 because of these concerns for breastfeeding difficulties/decreased milk supply.

Logistics

If a patient desires immediate PP LARC

Documentation & Consent Forms

- In Epic, any selected method should be added to the "Supervision of Pregnancy" Problem list under the "Contraception" section.
- If electing IPP LARC:
    - Add to 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 IMPLANT)
        - Use the dot phrase .BMCOBPPLARC under "Counseling for initiation of birth control method"
    - Complete the appropriate consent form at time of counseling and prior to presentation for delivery. Consent forms can be found in two locations:
        - On Sharepoint: Obstetrics and Gynecology
            - Consents OB and GYN →
            - BLANK CONSENT FORMS →
            - Family Planning Consents
        - On the Boston University website:
            - http://www.bumc.bu.edu/obgyn/, password bmcobgyn
            - Resources and Guidelines in the menu bar →
            - Departmental Resources →
            - Patient Consents [OB English]
            - Direct link: http://www.bumc.bu.edu/obgyn/ob-english-consents/
- **Completed consents**: Provide patient with a copy and then completed copies should be added to Yawkey folder to be scanned into OnBase in the patient record. For CHC patients: provide a copy to the patient and then scan and email to HIM Document Management HIMDocumentManagement@bmc.org to be added to OnBase

References

(1) Gariepy 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 A. Dot phrases for use in the electronic medical 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 in her ***R/L arm 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.

Appendix B. Additional Resources for Immediate Postpartum IUD Insertion from Partners in Contraceptive Choice and Knowledge (PICCK)

- **Postpartum LARC Counseling and Consent** – Best practices for LARC counseling during the prenatal period and how to document informed consent
- **Postpartum IUD Preparation and Equipment** - A quick reference for postpartum IUD preparation and equipment
- **Insertion of IUD Immediately Post Vaginal Delivery** – A quick procedure reference for IUD insertion within 10 minutes of vaginal delivery
- **Insertion of IUD During Cesarean Delivery** – A quick procedure reference for insertion during cesarean delivery
- **Insertion of Postpartum IUD Before Hospital Discharge** – A quick procedure reference for IUD insertion postpartum before discharge
- **Postpartum LARC Protocol**
- **Postpartum Contraception Decision Aid** – A postpartum contraceptive decision aid that is designed to explore patients' values and preferences for contraception postpartum. PICCK suggests using this decision aid when conducting contraceptive counseling prenatally to ensure shared decision-making
- **Providing Postpartum Contraception During COVID-19** – This document describes the need for postpartum contraception during COVID-19, lists best practices for providing postpartum contraception, and distinguishes between methods that are safe for immediate postpartum use, methods that become safe after 6 weeks postpartum, and methods that are not recommended for postpartum use
- **Postpartum LARC Toolkit** – A toolkit for providers and staff on implementing postpartum LARC services at their hospital, including sample protocols, counseling and consent best practices, and the evidence basis for immediate postpartum LARC
- **White Paper: Postpartum Contraception and Breastfeeding** – We review and present the literature on the impact of postpartum contraception on lactation, summarize the guidelines and recommendations of national organizations, and provide recommendations for you to use in counseling and provision of postpartum contraception for your patients.

Appendix C. Additional Resources for Immediate Postpartum IUD Insertion from ACOG

- **ACOG Committee Opinion: Immediate Postpartum Long-Acting Reversible Contraception** – The American College of Obstetricians and Gynecologists provides a Committee Opinion about immediate postpartum LARC. This document includes strategies for providers, information about the current LARC options, challenges, contraindications, additional information, and resources.
- **ACOG Postpartum Birth Control** – The American College of Obstetricians and Gynecologists answers frequently asked questions about postpartum birth control including available methods and their respective benefits and risks.

Appendix D. Medical Eligibility Criteria

- **WHO Medical Eligibility Criteria –** Please refer to the following with any questions regarding medical complications and contraceptive safety.
- **CDC Medical Eligibility Criteria** – easy to read chart with safety categories for each method