



Early Experience and Patient Perspectives of Immediate Post-Partum Placement of Intra-Uterine Contraceptive Devices

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Background

Immediate post-partum insertion of an intra-uterine contraceptive device (IUCD) has been proven to be safe with similar risks of perforation as interval insertion. There is a higher risk of expulsion with immediate insertion but despite this the usage of long acting contraception at 12 months remains higher with immediate insertion compared with a plan for delayed insertion.¹ Immediate post-partum IUCD insertion refers to insertion within 48 hours of birth, however the device is ideally inserted as soon as possible post-birth.²

Introduction

IUCDs are one of the most effective forms of contraception, have the benefit of being long-acting, reversible, affordable and are not affected by user failure. Because of these benefits IUCDs are commonly used overseas and inserted immediately post-partum, especially in resource-poor settings.

We introduced post-partum IUCD placement in a South Australian public hospital situated in a lower socio-economic area.

Methods

We offered post-partum IUCD insertion to women delivering vaginally or by Caesarean section. We conducted phone interviews and case note reviews of women who had post-partum IUCD placement from March to October 2020.

Results

TOTAL	27
Vaginal delivery	4
Caesarean	23
Spontaneous expulsion	0
Removed for medical indication	2
Removed due to lack of education/long strings	3

IUCDs had been removed for the following reasons.

- Early post-partum haemorrhage
- Endometritis
- Change of mind in the setting of UTI and initial reluctance to have IUCD
- Self removal of two due to long strings

Eight women had follow up ultrasounds of which seven showed correctly positioned IUCDs.

Patients reported high rates of satisfaction and 75% would recommend post-partum IUCD insertion to a friend.

We inserted 26 levonorgestrel IUCDs and one copper IUCD. Of the 22 women followed up who were discharged with an IUCD in situ, 82% still had their IUCDs in place. There were no significant adverse outcomes.

Discussion

Patient satisfaction was mostly due to convenience. One woman was dissatisfied due to endometritis. The other two who reported dissatisfaction did so due to bleeding – one felt her bleeding was heavy, the other too light.

In the early cohort, strings were not being trimmed prior to insertion at Caesarean. We identified that long strings were a risk factor for removal and multiple women presented for string trimming. We adjusted practice to trim the strings to 10cm prior to insertion. There were no reports of inappropriate IUCD removal following this.

We identified that insufficient midwifery education contributed to at least one IUCD being removed unnecessarily. This was in the setting of decreased education sessions during the pandemic. Staff should receive adequate education regarding post-partum IUCD placement so that correct advice can be provided to patients.

Immediate post-partum IUCD placement is safe, effective and offers patient satisfaction. Post-partum IUCD placement should be offered to women as part of contraceptive counselling.

References;

1. Goldthwaite, LM & Shaw, KA, 2015, 'Immediate post-partum provision of long-acting reversible contraception', Current Opinion in Obstetrics and Gynaecology, Vol 27 (6), pp. 460-464.

2. Whitaker, AK & Chen, BA, 2017, 'Society of family planning guidelines: postplacental insertion of intrauterine devices', Contraception, Vol 97 (1), pp. 3-13.