unity Sexual Health

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CaSH Update Day 11.5.21

IUD Workshops

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www.unitysexualhealth.co.uk

In partnership with:

bpas British Pregnancy Advisory Service
brook
The Eddystone Trust HIV and Sexual Health Services
Marie Stopes UK Children by choice, not chance
North Bristol NHS Trust
Terrence Higgins Trust
Weston Area Health NHS Trust

Case study 1 Expulsion scenario

- 32 years old, 2 x NVD, wants non –hormonal method.
- Last delivery 1 year ago, IUD fitted immediately Post Partum, expelled 1/52 later.
- Second attempt 6 months later expelled 6/52 later. She wants another attempt.
- How would you proceed?

Discussion points/prompts

- Explore why Cu IUD so important
  - Would IUS be more appropriate?
  - Could offer lower dose Kyleena if patient is worried about hormonal side effects.
- Explore possible reasons for expulsion
  - Fibroids? Anatomical variant?
  - Difficult fit? Pain post fit?
  - Higher risk postpartum

Discussion points / prompts

Expulsion after postpartum fits -

- Benefit may outweigh disadvantage!
- Increased expulsion risk for 3 months
- Must be made aware, taught thread check and indicators of expulsion

	Immediate	Delayed
Pain at fit	LOWER	higher
Expulsion rate	HIGHER (OR 4.9)	Lower
Continuation rate (6-12 months)	HIGHER (OR 2.0)	Lower

- Moon cups, tampons?
  - Manufacturer says wait 6 weeks.
  - Evidence inconclusive about risk of expulsion.

Suggested Management;

- Discuss expulsion with patient
  - Possible causes, symptoms
  - Thread check

Discuss other contraceptive options

- USS to check for uterine anatomy; mass e.g. fibroid, bicornuate **uterus**

- Local BNSSG pathway:
  - Refer to Unity Dr Singh for possible Gynaefix
  - Although no evidence they have lower expulsion rate.

- **https://www.wildemeersch.com/products/gynefix/insertion-procedure/**

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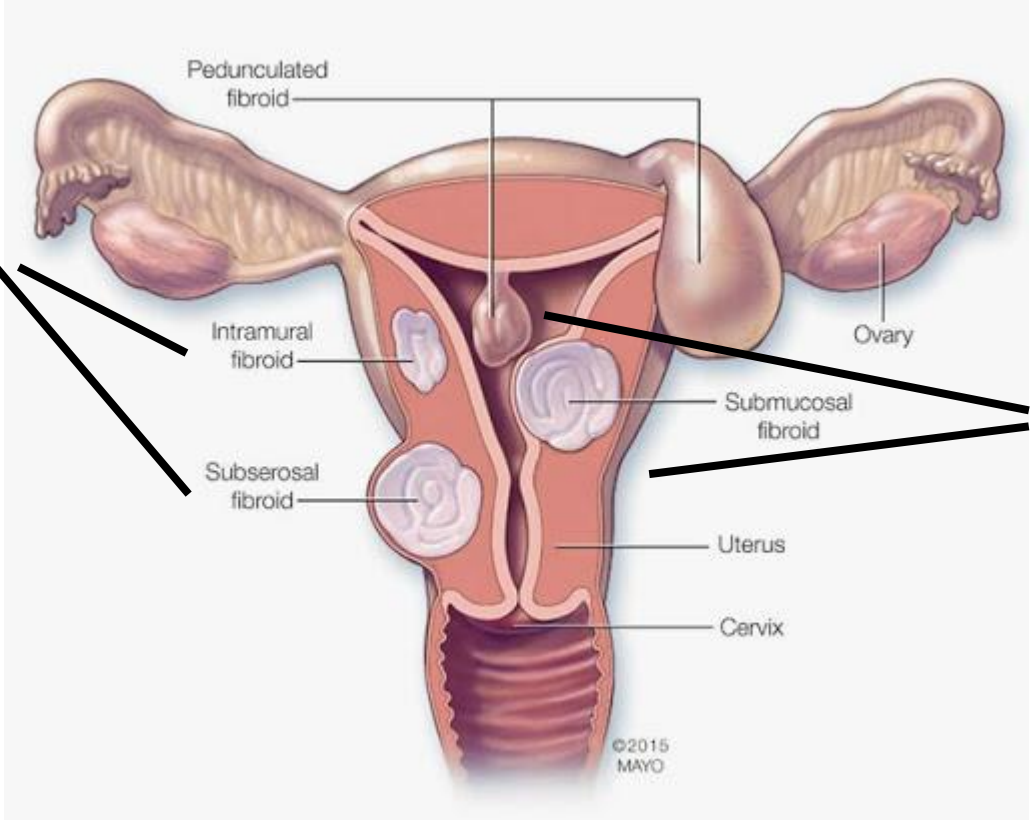
Suggested Management;

If fibroid is not distorting the cavity

Contraception: UKMEC 1.

NICE heavy menstrual bleeding (HMB):

First line treatment for fibroids under 3cm not distorting cavity is IUS



If fibroid is distorting the cavity

Contraception:
UKMEC 3
Due to risk of expulsion. But studies not statistically significant. Rate of expulsion 0-20%

Also risk of inconsistent endometrial effect

Therefore not recommended

For general fibroid management it may still be a good option but may need specialist/ gynaecology input e.g. hysteroscopy and additional contraception

Local pathway:

MDT discussion based on images,size of fibroid etc.

Case study 2 - lost threads scenario

17yr old had an emergency IUD fitted and was advised to check threads at 6 weeks. Unable to feel threads, so they've contacted your service. How do you approach the case?

What could have led to this finding?

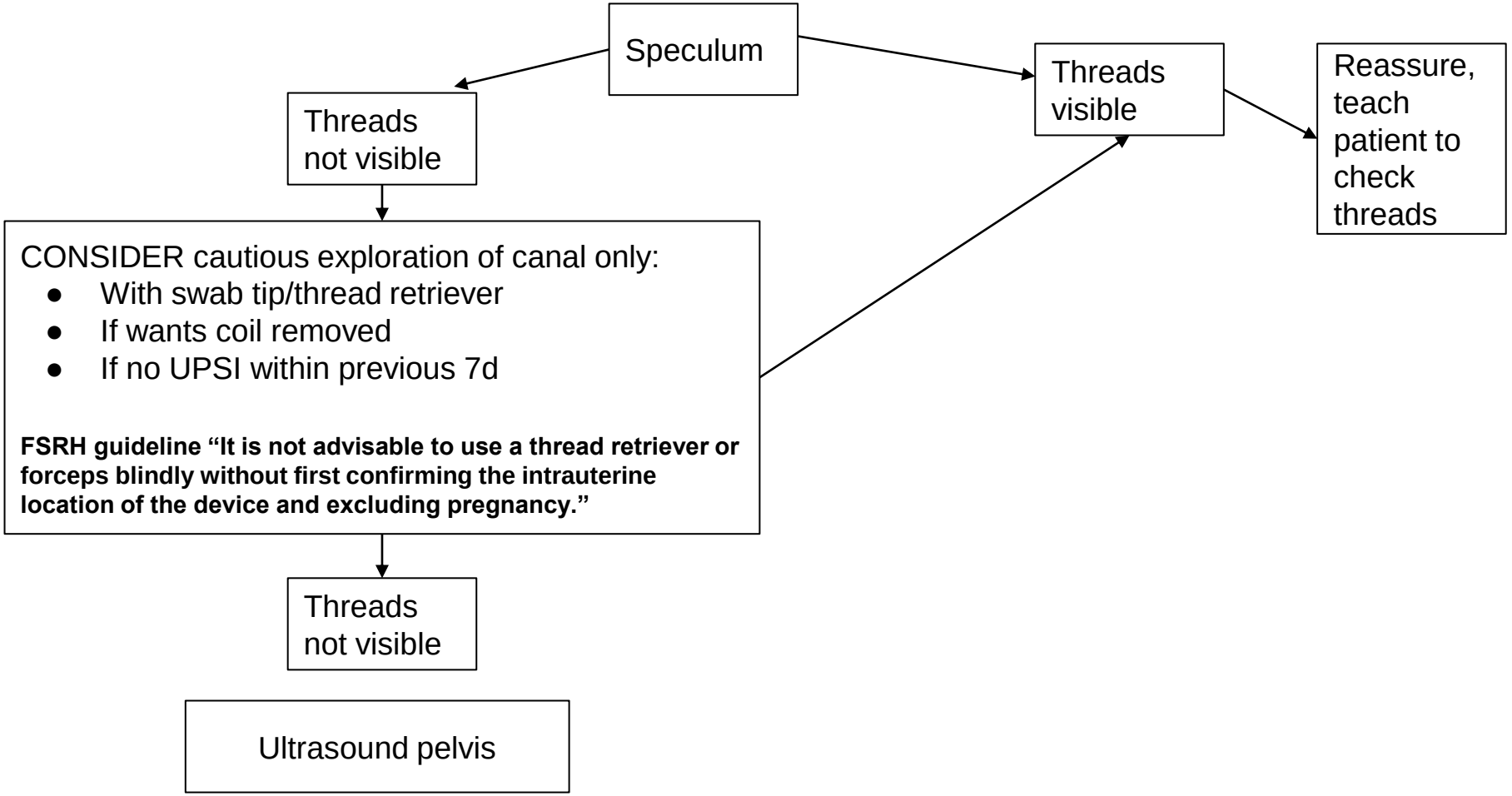
- Threads have retracted into uterus/have curled out of reach (most common)
- Expulsion 1 in 20 fits (+- subsequent pregnancy risk)
- Perforation 1 in 1000 fits (increased 6-12 x postpartum/breastfeeding)

- Signs/symptoms of possible perforation – acute pain at/ from time of fit, history of difficult insertion. However sometimes painless and unsuspected.

- FSRH guideline: "Mild lower abdominal pain, 'lost threads', changes in bleeding (LNG-IUS) and a history of pain at the time of insertion may indicate uterine perforation."

- If patient is unwell (significant pain, signs of sepsis) they would need an urgent gynae assessment (for both perforation and infection)

How would you manage this?



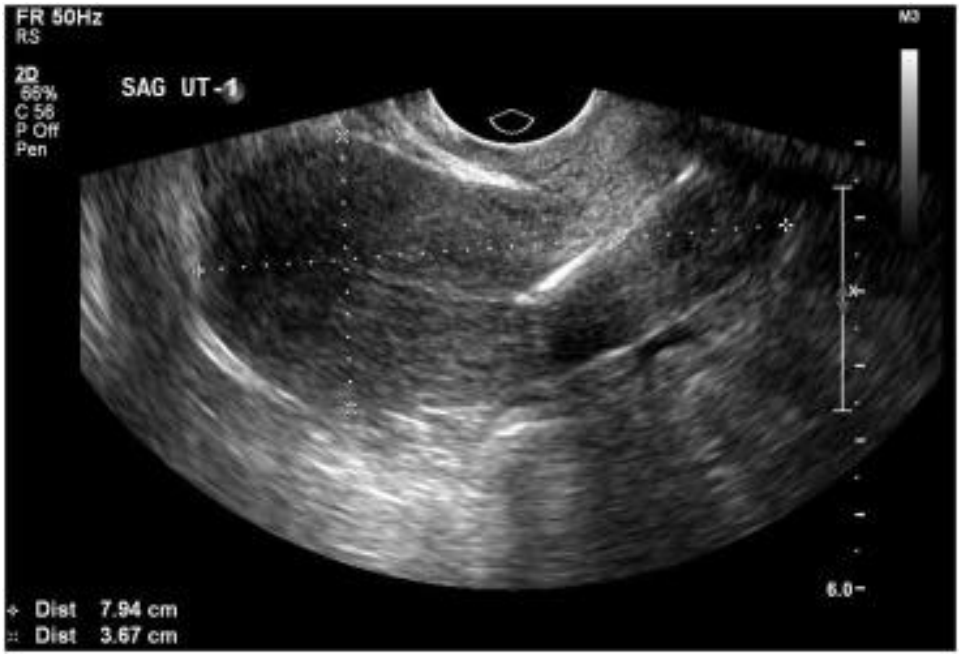
What if the scan shows an IUCD in the uterus?

- USS pelvis
  - IUCD not seen → Requires CT abdo/pelvis
  - IUCD seen
    - Correctly positioned → Safe to leave in until removal date/patient choice
    - Not correctly positioned (>2cm from fundus) → Efficacy not guaranteed

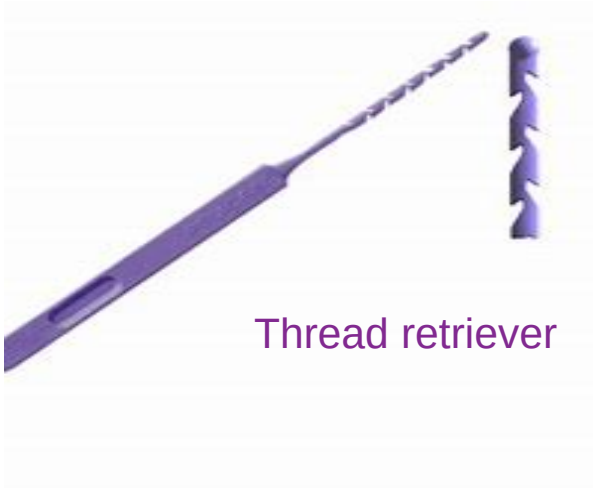
      Recommend removal

Unity "Lost threads removal":

- USS within 12 months
- Possibly longer procedure, may need cervical block
- Rarely requires hysteroscopy



“Lost threads removal” equipment

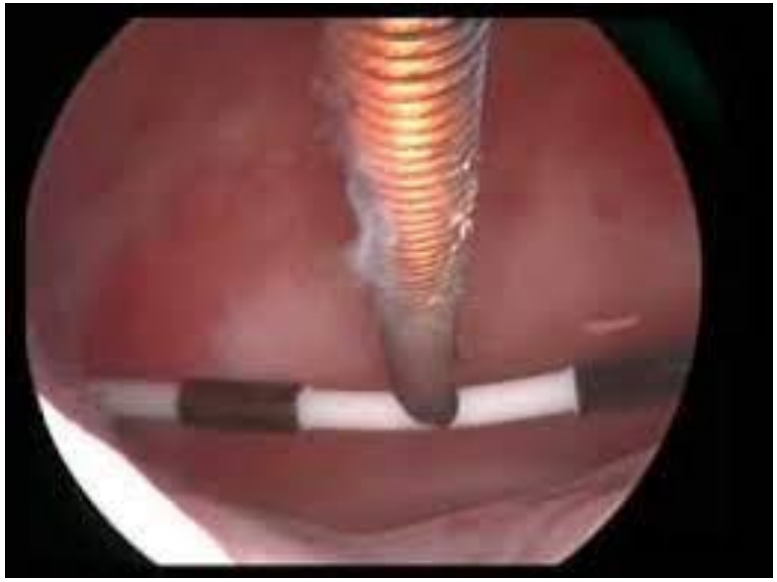


Thread retriever

Crocodile forceps

Dental syringe

Hysteroscopic removal

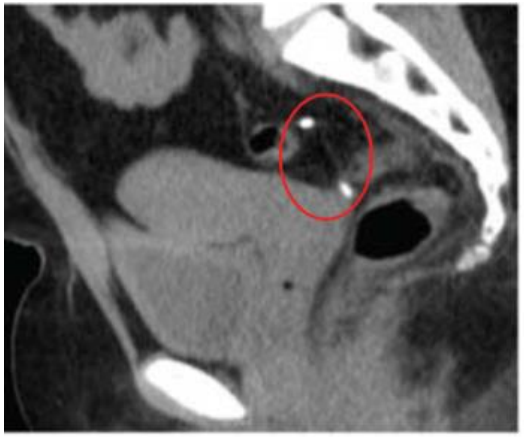


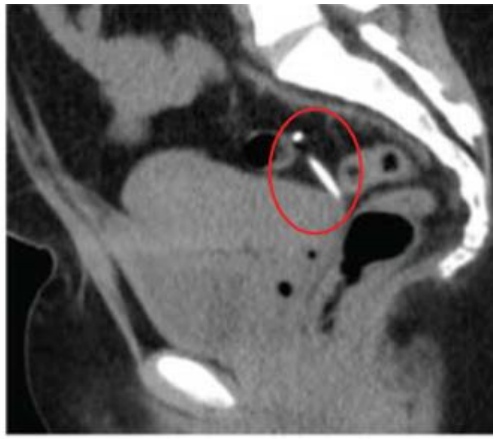
Hysteroscopic view of IUCD

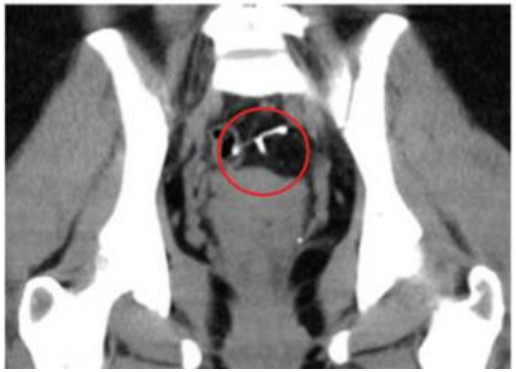
Hysteroscopic graspers

What if scan shows IUCD not in uterus

- Most likely it has expelled but must exclude a perforation
- CT scan of abdomen
  - now recommended in most centres over AXR as more sensitive and lower radiation
- Removal following perforation
  - Laparoscopic removal, usually non-urgent.
  - Laparoscopic removal is not a medical emergency unless bowel or vessel perforation suspected







How do you teach a patient to check their threads?

- Provide tactile memory: get them to feel threads in clinic
- Consider using a model
- Help orientate them to the anatomy- e.g. drawings
- Resources- Unity video in development. Collaboration with locaL artists

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1. Get in a comfortable position of your choice. Squatting, lying down, or one foot up might help

1. Get warm, feel secure, maybe lock the door

1. You might like to use a mirror and some lube

1. Some women choose to self-examine during a period, when there's some more natural lubricant.

5. Gently slide a finger or 2 into the entrance of your vagina (you might want to use a mirror to guide you)

6. The first thing you may notice are the normal ridges of your vaginal wall.

7. Your vagina is flexible and tube-shaped and the walls feel soft. The walls will be touching each other until your fingers part them

8. Practice tensing your pelvic floor muscles* (this should feel like a squeeze) now let go,

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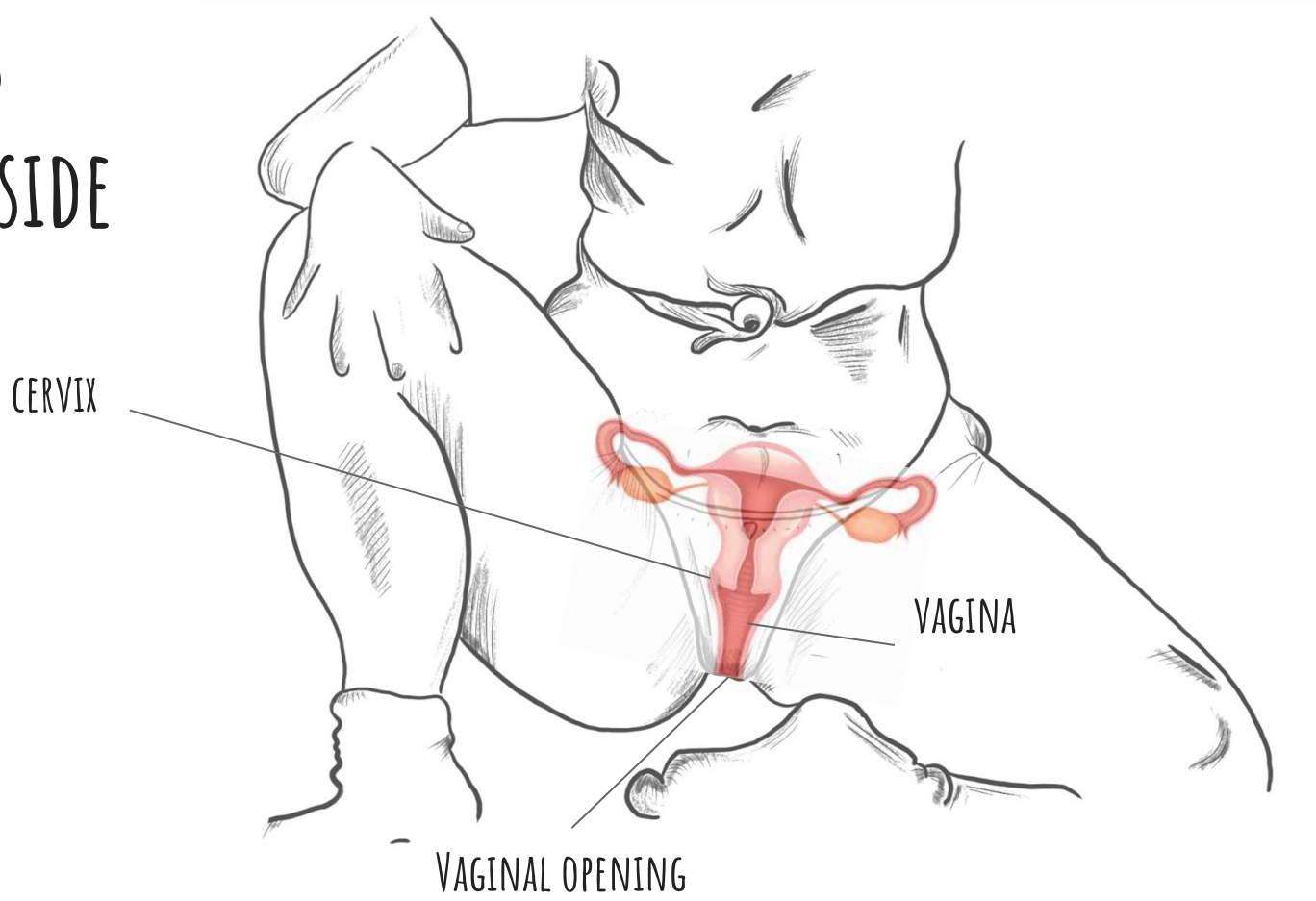
Here's what's going on inside



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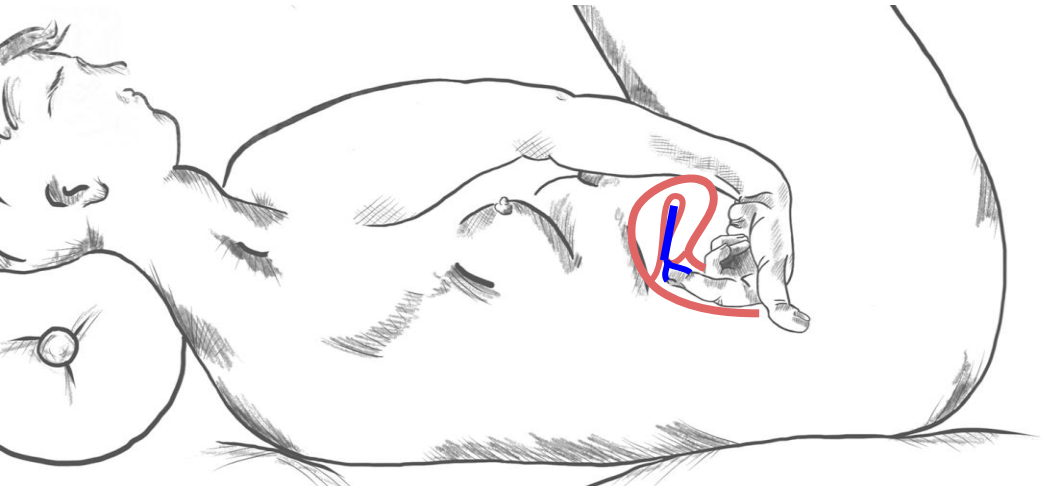
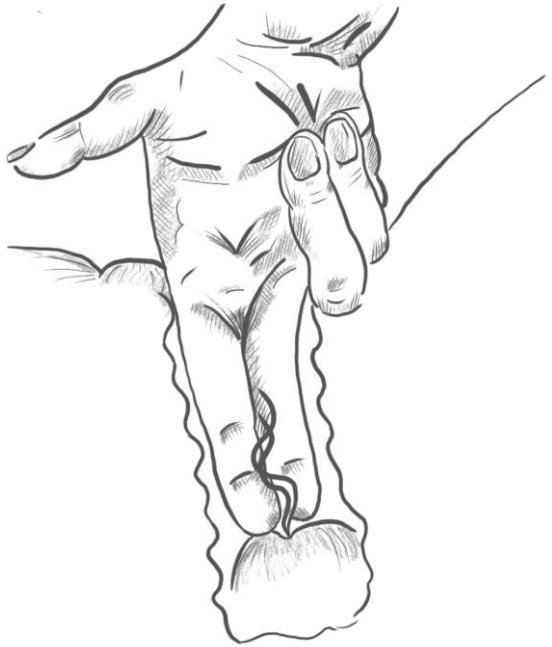
9. Slide your fingers up and slightly backwards (towards your spine, away fro your belly button)

10. Your cervix will be at the top (deepest part) of your vagina

11. Your vaginal walls are soft (similar to your cheeks if you're not grinning!)

12. If you've tensed your muscles, see if you can let the muscles go soft as this might help you reach your cervix.





13. Your cervix is smooth and firm/springy (similar to booping your nose!)

14. If hunting for coil threads, gently pass your finger tip over the surface of your cervix, you may feel a dimple.

15. Threads are normally felt coming from this dimple and will feel like thick cotton thread

Case study 3

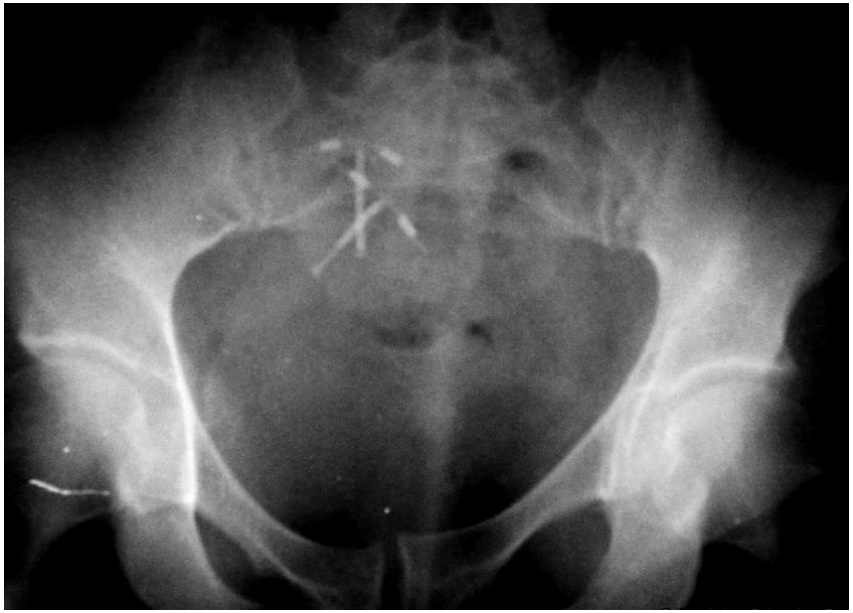
46 year old presented with IMB and HMB with IUD in situ for 7 years.

- Seen in 2 week wait hysteroscopy clinic and findings were of two IUDs in situ.
- One IUD was located in the cervix with degraded copper on the stem and nil on the arms.
- Second IUD correctly sited in uterus at fundus.

- What's gone wrong here?

- Patient had previously had an IUD in situ for 10 years which expired and then attended GP surgery for removal and refit with current IUD 7 years ago.
- Assumed that must have been lost threads when attended for removal and refit and therefore 2 IUDs ended up in situ with patient experiencing bleeding symptoms.
- Both IUDs removed and new IUD fitted as would not be able to definitely determine which IUD was in date.

(Xray image of similar case)



Learning Points

- Lost threads - actions to take and pathway
- Expulsion causes and solutions
- Self examination

- For local GP referral pathways and more information:

https://remedy.bnssgccg.nhs.uk/adults/sexual-health/larc-complex-referrals/