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Examining Long-Acting Reversible Contraceptive Methods

Dr. Prathima Setty:
Hello. This is Dr. Prathima Setty and I'm your host for this segment on Reach MD. Today we are speaking with Dr. Eve Espey. Dr. Espey is the Chairperson of the Department of OB-GYN, Professor in the Division of Family Planning and Fellowship Director for the Family Planning Program at the University of New Mexico. She is also President Elect of the Society of Family Planning and is the Medical Advisory Committee Chair for the National Campaign to Prevent Teen and Unplanned Pregnancy. She has won numerous teaching awards and has also received the prestigious Rashbaum Award for recognition of her impact on training and service in abortion provision. She has numerous publications and has presented nationally on the topics of contraception and abortion.

Dr. Espey, thank you so much for joining us here today.

Dr. Eve Espey:
Thank you.

Dr. Prathima Setty:
In the recent, there has been a real focus and attempt to use more long-acting reversible contraceptive methods in clinical practice, can you comment on why you think is so?

Dr. Eve Espey:
The increase in interest in long-acting reversible contraceptives really goes along with their tremendous effectiveness and their great side effect profile. It's increasingly been recognized that the majority of women are good candidates for both of the long-acting methods, both the intrauterine device, the IUD, as well as the contraceptive implant.

In the past there were concerns about who good candidates were for these methods, and these days a very large body of evidence points to the safety and effectiveness of these methods. So, they really have the opportunity to reduce the very high rate of unintended pregnancies that we see in this country.

Dr. Prathima Setty:
And have you found that these long-acting reversible contraceptive methods, are they more effective than birth controls pills and the patch, NuvaRing, those other types of methods that we generally have used in the past?

Dr. Eve Espey:
Yes. So, we consider the long-acting methods to be the IUD and the contraceptive implant, and the short-acting methods are the ones that you talked about which are the birth control pill, the patch and the ring and to some extent Depo-Provera. Depo-Provera is the shot that you get every three months and even though that's a longer-acting method, it still requires multiple acts of motivation to continue the method. So, what's been found, particularly in a recent research project called the Contraceptive Choice Project, is that the long-acting methods, the IUD and the implant, are about 20 times more effective in preventing unintended pregnancy than the short-acting methods. So, that's why there's such a focus on these methods because they work so much better.

Dr. Prathima Setty:
So, as far as counseling a patient in the office with the different options of IUD, Mirena versus ParaGard and for that matter, the Nexplanon or Implanon, how do you approach this? How do you present these options?

Dr. Eve Espey:
So, it's always very important to present contraceptive options to women in a way that they have the choice of options, so there are a

number of different choices including the short-acting methods as well as the long-acting methods. However, just the way we would present options for other medical conditions, for example hypertension, we would talk about the most effective methods first, that's the way I approach talking to women about contraceptive methods in terms of the long-acting methods. So, again, very important for women to make their own choice, but I do tend to open the conversation about contraceptive options talking about the IUD and the implant.

Now, in terms of those options, the copper IUD is a ten-year option. It's very good for women who desire a non-hormonal method or who want contraception for greater than a year. There is sometimes increased bleeding or cramping with periods with the copper IUD. The hormone IUD lasts for five years. It most often reduces menstrual bleeding and for some women there is no bleeding at all. That's a great option again for women who desire contraception for a longer term period, more than six months to a year. And again, both of these methods are what we call forgettable meaning once they're initiated there's no ongoing maintenance that's needed.

In terms of the Nexplanon, that's the contraceptive implant. Again, good for women who desire longer term contraception for more than six months to a year. There are some leading irregularities with the Nexplanon that may be well accepted by some women, but not as well accepted by others.

Dr. Prathima Setty:
So, are there any absolute contraindications for the IUD?

Dr. Eve Espey:
So, absolute contraindications are few and far between. They include an active pelvic infection within the past three months. They include a uterine cavity that is unable to accept an IUD, so if there is an abnormality of the cavity of the uterus, there are some uterine abnormalities that cause the shape of the uterus to be such that an IUD can't be placed, so that's an absolute contraindication. Obviously, pregnancy is an absolute contraindication to the IUD.

Dr. Prathima Setty:
So, do you do an ultrasound prior to insertion for these women to check and see if they have uterine abnormalities or do you generally don't do that?

Dr. Eve Espey:
We generally don't do that. Uterine abnormalities are pretty unusual and many uterine abnormalities, for example, we think of the uterus as triangular in shape in terms of the cavity, uterine abnormalities may be where one side of the uterus is much bigger than the other. Many common uterine abnormalities are such that an IUD can be placed.

Dr. Prathima Setty:
And still be effective, is that...

Dr. Eve Espey:
And it's still effective, yes. Ultrasound prior to IUD placement is rarely needed unless there is an abnormality that's suspected.

Dr. Prathima Setty:
So, what do you quote as the risk of pregnancy with a properly-placed IUD versus Nexplanon, I'm assuming very, very low.

Dr. Eve Espey:
Both are very low. The pregnancy rate with the IUD, both the copper and the hormone, we quote at about one percent or slightly less whereas with the Nexplanon it's actually much less than one percent. So, looking at the two methods side by side, Nexplanon is far more effective even than the IUD, but IUDs are so highly effective that we do consider them all in the same group.

Dr. Prathima Setty:
So, what do you quote as the amenorrhea rate after Mirena versus Nexplanon, are they similar?

Dr. Eve Espey:
The Mirena has a higher rate of amenorrhea than Nexplanon and it's more predictable. About 20 percent of women after a year have amenorrhea with the Mirena and that percentage increases over time whereas one of the difficulties in counseling women about the Nexplanon is that the bleeding pattern is often unpredictable. So, a woman may have a period of amenorrhea, but may then have several months of irregular bleeding. So, although amenorrhea does occur with about 20 percent of women with the implant, it's difficult to predict who those women will be and whether that pattern will sustain over time.

Dr. Prathima Setty:
So, how do you manage those bleeding abnormalities after IUD placement? Oftentimes you hear women who have a lot of bleeding after these IUD placements, what is considered acceptable and how do you manage that?

Dr. Eve Espey:
The major complaint with the copper IUD is heavy bleeding with cramping. The main complaint with the hormone IUD is irregular bleeding or no bleeding, so it's very important upfront to counsel women that they may have very little or no bleeding with the hormone IUD. With the Nexplanon it's irregular, unpredictable bleeding. So, for example with the hormone IUD and the copper IUD, the rates of discontinuation due to bleeding are similar. It's about ten percent in the first year, but the reasons for discontinuation are different, one is too much bleeding, the other is irregular bleeding. Similarly with the contraceptive implant, irregular bleeding leads the list of reasons why women stop using the implant.

Dr. Prathima Setty:
What would be considered acceptable time for the patient as far as their bleeding issues, a few months? And do you give them any medication to help with the bleeding at that time?

Dr. Eve Espey:
So, for the copper IUD we often recommend using nonsteroidal anti-inflammatories. Use of Ibuprofen, for example, not only reduces cramping with the IUD, but it also reduces the volume of bleeding, so that's a commonly prescribed medication in women who use the copper IUD. For the hormone IUD we usually counsel that irregular bleeding is most likely time-limited within about three months. We will counsel that the woman may experience irregular bleeding for up to three months. After three months the most common pattern is either oligo-amenorrhea or complete amenorrhea.

When women come in...let's say a woman comes in at six months still complaining of irregular bleeding with the hormone IUD, I will sometimes, if she is an appropriate candidate, recommend one to three months of oral contraceptives to see if that makes an impact. There's not a huge amount of data for that, but it may help with the bleeding pattern and allow a woman to continue an IUD that she would otherwise discontinue.

I do a similar approach with women using the contraceptive implant. If the most common reason that women want the implant removed is because of daily spotting or daily heavier bleeding, sometimes giving a short trial of oral contraceptives on top of the implant will help alleviate the problem.

Dr. Prathima Setty:
And do you generally use a 20 microgram combination pill or do you go higher than that? What is your general practice?

Dr. Eve Espey:
I usually use a 30 or 35 microgram pill most commonly because it's cheaper. The Sprintec, which is a generic of a 35 microgram pill, is available at certain pharmacies for $9 a month whereas other oral contraceptives are significantly more expensive. But also, the 30 or 35 microgram pills tend to do a slightly better job with really alleviating the bleeding irregularity that tends to be frustrating the patient very much at that time.

Dr. Prathima Setty:
So, do you ever do an endometrial biopsy with the IUD in place in those patients who have continued abnormal bleeding or is that generally not a practice that you do?

Dr. Eve Espey:
No. So, two situations, one is in a woman with a hormone IUD irregular bleeding is expected. Also, we know that the hormone IUD has a great reduction in risk of uterine cancer as one of its non-contraceptive benefits, so the likelihood of an endometrial cancer in a young woman using a hormone IUD is extremely low. Now, conversely in a woman with a copper IUD who develops unscheduled bleeding who's over 35, we will typically do an endometrial biopsy, but leave the IUD in place. There's no reason to remove the IUD just to do an endometrial biopsy.

Dr. Prathima Setty:
So, in that situation does the IUD get in the way of doing the biopsy because it's in the uterine cavity?

Dr. Eve Espey:
Yeah. But as it turns out it does not disrupt the IUD, and the IUD does not interrupt the ability to perform the biopsy.

Dr. Prathima Setty:
What are some tips that you give providers to avoid perforation of the uterus, that's always something all providers are worried about doing at the time of insertion. What is some guidance that you can give those clinicians?

Dr. Eve Espey:
I think the most important tip for preventing perforation is to use the same technique described in the package insert for IUD insertion,

particularly when a provider is new at performing IUD insertions. So, for example, I'm in a teaching institution, so I'm always teaching somebody to place an IUD, so I follow the package insert directions very closely. So, for example, I always place a tenaculum, I always sound the uterus, and then use the appropriate technique again as described in the package insert.

Now, for providers who are very experienced with IUD insertion, removing the step of using the tenaculum or of sounding the uterus may be practiced, but I think particularly during that learning curve with difficult IUD insertions, really following the same standardized technique with every IUD insertion can be quite helpful.

Dr. Prathima Setty:
And what about those patients with a severely retroverted or severely anteverted uterus, do you ever have difficulty placing the IUDs in those situations, or can you offer any advice on those types of patients?

Dr. Eve Espey:
In the setting of a difficult IUD insertion and when my manual exam has demonstrated that the uterus is severely anteverted or retroverted, occasionally ultrasound guidance may be helpful. Most of the time with careful technique, ultrasound guidance is not needed, but I think with any difficult IUD insertion there are other factors that may help making sure that the patient is comfortable. So, for example, either giving PO narcotics or considering a paracervical block, using other instruments, an Os finder or dilators, having those kinds of instruments on hand for the difficult IUD insertion can be quite helpful.

Dr. Prathima Setty:
So, do you generally remove an IUD and place another one in the same day or do you have them come back?

Dr. Eve Espey:
Absolutely, same day. I think we really need to change the way we approach contraception in general, that it's an emergency, so anything that we can do the same day we should do the same day. We have a same-day insertion protocol for placing IUDs, so if a woman comes in and we can reasonably rule out pregnancy, we will place the IUD on the same day.

Dr. Prathima Setty:
And as far as ruling out pregnancy, do you check a pregnancy test on all your patients before insertion or what's your general protocol with that?

Dr. Eve Espey:
We do a pregnancy test on all women unless, for example, they have an IUD in place at the time that they come in or another long-acting method. We follow the United States Specific Practice Recommendations for how to reasonably rule out that a woman is pregnancy. So, we ask about whether she's had unprotected sex within the last week or two prior to her presentation as well as doing the pregnancy test.

Dr. Prathima Setty:
So, in the office I've often heard of patients complaining of mood changes, weight gain and other progesterone type of effects after Mirena placement, do you think this is common and how do you manage that?

Dr. Eve Espey:
Hormone-related side effects, we definitely hear those complaints with both the Mirena IUD and with the Nexplanon. The amount of hormone released by the hormone IUD is very small, so many of those complaints are unlikely related to the hormone. For example, weight gain, studies have not documented weight gain with the hormone IUD, but in general if patients believe that they have side effects that are caused by hormones it can be difficult to change their minds or their attitudes about that. So, in general I am guided by what patients want. Oftentimes reassurance is helpful. For example, weight gain, reassuring patients that studies don't show evidence of weight gain either with the contraceptive implant or with the hormone IUD, that can be helpful, talking about diet and exercise, for example, but sometimes people feel very strongly that their side effects are related to hormones and then another conversation is necessary.

Dr. Prathima Setty:
So, in those instances do you sometimes have to take the Mirena out?

Dr. Eve Espey:
Yes. And again, I think that gets back to women should have a free choice of contraceptive methods and initiating and ending them whenever they want. Somebody may come in and say they have a side effect that they are sure is related to the device that I may not think is related to the device, but ultimately the patient is in charge and it's very important to honor their wishes.

Dr. Prathima Setty:

Another question for you, Dr. Espey, how do you manage someone who comes in for an IUD check and you look inside the vagina with a speculum and you don't see the IUD string, how would you manage that?

Dr. Eve Espey:
The first test to do when there is no IUD string is an ultrasound. We're fortunate in our office, we have both transabdominal and transvaginal ultrasound and most frequently performing an ultrasound will confirm the presence of the IUD. The copper IUD is much easier to see on ultrasound than the hormone IUD. Occasionally it's very easy to see the hormone IUD, but sometimes it's more subtle, but most of the time we can verify the presence with ultrasound. If the ultrasound does not show an IUD in the uterus then the next step is to do an X-ray of the abdomen and it's very important in that X-ray to visualize the entire abdomen and pelvis in order to locate a potentially perforated IUD that's wound up in the intraabdominal location.

Dr. Prathima Setty:
So, in the instance that you need to take the IUD out and you can't see the string, what are some tips that you can give clinicians with that experience?

Dr. Eve Espey:
So, if the IUD is in the uterus, but there are no visible strings there are two instruments that are very helpful in removing the IUD. The traditional instrument is called an IUD hook. It's a metal instrument that has a pronounced hook at the end, but actually a much better instrument is the IUD removal forceps. There is one in particular that's spelled, it's a French name, Mathieu, M-A-T-H-I-E-U, IUD removal forceps. It's a small alligator forceps that is so small it's very easy to sneak it up both into the endocervical canal as well as into the uterus in order to grab either the body of the IUD or the string, and I think anybody who practices contraception should have one of these alligator IUD removal forceps.

Dr. Prathima Setty:
And in your experience have you ever seen an IUD imbedded in the uterus preventing removal?

Dr. Eve Espey:
There have been IUDs that are either imbedded or are configured in such a way in the uterus that they're difficult to remove, and occasionally those patients we take to surgery for an operative hysteroscopy where we place an endoscope into the uterus in order to facilitate the removal.

Dr. Prathima Setty:
So, can you discuss placement of IUDs after delivery? What is your expulsion rate and do patients get frustrated if they pay for an IUD and then it comes out? What's your experience with that?

Dr. Eve Espey:
We do quite a bit of immediate postpartum IUD placement in our hospital. We're fortunate to live in a state where Medicaid covers immediate postpartum IUD insertion as well as implant placement prior to hospital discharge after a delivery. So, we've developed a transcesarean technique where we place the IUD right after the baby and the placenta have been removed after a C-section and a ring forceps technique for placing the IUD in the uterus right after a vaginal delivery.

The expulsion rate is variable. In the literature the expulsion rate varies from about ten percent to about 30 percent, so it's very difficult with the existing data to know exactly where that expulsion rate is. It also appears to decline with experience, so the more experience a provider has, the lower the expulsion rate likely is with postpartum IUD insertion.

Dr. Prathima Setty:
Well, thank you very much, Dr. Espey, for being with us today and for sharing with us your thoughts on this important topic.

Dr. Eve Espey:
Oh, no problem at all. Thank you for doing it.

Dr. Prathima Setty:
I'm your host, Dr. Prathima Setty, and you've been listing to Reach MD. If you missed any part of this discussion, please visit ReachMD.com to download this broadcast. Thank you for listening.