Complete Summary

GUIDELINE TITLE

Intrauterine contraception.

BIBLIOGRAPHIC SOURCE(S)

Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. Intrauterine contraception. London (UK): Faculty of Sexual and Reproductive Healthcare; 2007 Nov. 21 p. [133 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Unintended pregnancy

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention
Risk Assessment
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence based recommendations and good practice points for clinicians on the use of intrauterine contraception as a long-term option to prevent pregnancy

TARGET POPULATION

Women considering intrauterine contraception as a long-term option

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation/Risk Assessment

1. Assessment of medical eligibility criteria for use of intrauterine contraception
2. Clinical history
3. Testing for sexually transmitted infections (STIs)
4. Antibiotic prophylaxis for women with previous endocarditis or prosthetic heart valve

Counseling/Management/Treatment

1. Counseling women on risks and benefits of intrauterine contraception
    - Mode of action of copper-bearing intrauterine device (Cu-IUD) and levonorgestrel-releasing intrauterine system (LNG-IUS)
    - Efficacy and failure rates
    - Duration of use
    - Risks
    - Return to fertility
    - Non-contraceptive benefits
    - Choice of device
2. Insertion of device
    - Timing of insertion
    - Safe insertion
    - Training
    - Informed consent
    - Pain relief
    - Management of emergencies

- Practical considerations
- Documentation
- Information for women for routine follow-up after insertion
    - Expected duration of use and consideration of removal
    - Checking threads and device
    - Reducing the risk of sexually transmitted infections (STIs)

3. Management of problems associated with intrauterine contraception
    - Suspected perforation at time of insertion
    - Lost threads
    - Abnormal bleeding
    - Pregnancy
    - Suspected pelvic infection
    - Presence of actinomyces-like organisms
4. Removal of intrauterine contraception

MAJOR OUTCOMES CONSIDERED

- Risks, benefits, safety, and efficacy of intrauterine devices
- Rate of failure of intrauterine contraceptive device, unintended pregnancy

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Evidence is identified using a systematic literature review and electronic searches are performed for: MEDLINE (CD Ovid version) (1996–2007); EMBASE (1996–2007); PubMed (1996–2007); The Cochrane Library (to 2007) and the US National Guideline Clearing House. The searches are performed using relevant medical subject headings (MeSH), terms and text words. The Cochrane Library is searched for systematic reviews, meta-analyses and controlled trials relevant to intrauterine contraception. Previously existing guidelines from the Faculty of Sexual and Reproductive Healthcare (FSRH) (formerly the Faculty of Family Planning and Reproductive Health Care [FFPRHC]), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization and the British Association for Sexual Health and HIV, and reference lists of identified publications, are also searched. Similar search strategies have been used in the development of other national guidelines.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Ia Evidence obtained from meta-analysis of randomized controlled trials

Ib Evidence obtained from at least one randomized controlled trial

IIa Evidence obtained from at least one well-designed, controlled study, without randomisation

IIb Evidence obtained from at least one other type of well-designed quasi-experimental study

III Evidence obtained from well-designed non-experimental descriptive studies, correlational studies, and case studies

IV Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Selected key publications are appraised using standard methodological checklists similar to those used by the National Institute for Health and Clinical Excellence (NICE). All papers are graded according to the Grades of Recommendations Assessment, Development and Evaluation (GRADE) system Summary evidence tables are available on request from the Clinical Effectiveness Unit.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Draft One Guidance document is written, providing recommendations and good practice points based on the literature review. The Clinical Effectiveness Unit has overall responsibility for writing the Guidance document. The Multidisciplinary Group and other peer reviewers should highlight inconsistencies and errors or where the text is incomprehensible. A Multidisciplinary Group Meeting is held, comprising stakeholders and including service user representation, representation from the Faculty of Sexual and Reproductive Healthcare (FSRH) Education Committee and, where possible, representation from the FSRH Clinical

Effectiveness Committee (CEC) and FSRH Council. A one-day meeting is held in Aberdeen with the Multidisciplinary Group to discuss the Draft One Guidance document.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point: Where no evidence exists but where best practice is based on the clinical experience of the Multidisciplinary Group

COST ANALYSIS

Increasing the uptake of long-acting reversible contraception (LARC) methods such as copper bearing intrauterine device (Cu-IUDs) or the levonorgestrel-releasing intrauterine system (LNG-IUS) can reduce the number of unintended pregnancies. The long-term use of intrauterine contraception is highly cost effective. Intrauterine contraception is more cost effective than combined oral contraception (even at 1 year of use) or progestogen-only injectables.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Draft Two Guidance document is peer reviewed by the Multidisciplinary Group and the Faculty of Sexual and Reproductive Healthcare (FSRH) Clinical Effectiveness Council (CEC). All written feedback on the Draft Two Guidance document is tabulated and the Clinical Effectiveness Unit (CEU) response to these comments is outlined. The Draft Three Guidance document is prepared based on written feedback and is sent to the Multidisciplinary Group and the FSRH CEC. In addition, two independent reviewers are identified by the CEC to provide feedback at this stage. Only minor comments can be accepted at this stage. The Final Guidance document is published by the FSRH. Proofreading of the Guidance is then performed by three members of the CEU team independently and comments collated and sent back by the Unit Director. A portable document format (pdf) version of the Guidance is made available on the FSRH website.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The recommendation grades (**A to C, Good Practice Point**) are defined at the end of the "Major Recommendations" field.

Which Women Are Eligible to Use Intrauterine Contraception?

1. Health professionals should be familiar with *UK Medical Eligibility Criteria for Contraceptive Use* recommendations for intrauterine contraceptive use (**Good Practice Point**).

Note: Table 2 in the original guideline document summarizes the *UK Medical Eligibility Criteria for Contraceptive Use* where a copper intrauterine device (Cu-IUD) and the levonorgestrel-releasing intrauterine system (LNG-IUS) are given the same UKMEC categories and highlighting where categories differ between the Cu-IUD and the LNG-IUS6.

What Should Clinicians Assess When a Woman Is Considering Intrauterine Contraception?

Clinical Assessment

2. A clinical history (including sexual history) should be taken as part of the routine assessment for intrauterine contraception to assess suitability for use of the method and identify those at *higher risk* of sexually transmitted infections (STIs) (i.e., those aged <25 years, or >25 years with a new sexual partner or more than one partner in the last year, or if their regular partner has other partners) (**Grade C**).
3. In advance of intrauterine contraceptive insertion women who are either at *higher risk* of STI or who request swabs should be tested for *Chlamydia trachomatis* (as a minimum) and *Neisseria gonorrhoeae* (if deemed necessary from the history) (**Good Practice Point**).
4. For women at *higher risk* of STIs, if results are unavailable before insertion prophylactic antibiotics (at least to cover *C. trachomatis*) may be considered (**Good Practice Point**).
5. In *asymptomatic* women attending for insertion of intrauterine contraception there is no indication to test or treat other lower genital tract organisms or delay insertion until the results of tests are available (**Good Practice Point**).
6. Women with previous endocarditis or with a prosthetic heart valve require intravenous antibiotic prophylaxis to protect against bacterial endocarditis during intrauterine contraception insertion or removal (**Grade C**).
7. When prophylaxis against bacterial endocarditis is required, clinicians should refer to the British National Formulary (*BNF*) for the most up-to-date regimen and ensure the intrauterine contraceptive procedure takes place in an appropriate setting (**Good Practice Point**).

What Information Should Be Given to Women When Counselling Them About Intrauterine Contraception?

Mode of Action

8. Women should be informed that the primary mode of action of a Cu-IUD is prevention of fertilisation (**Grade B**).

9. Women should be informed that the LNG-IUS works primarily by its effect on the endometrium preventing implantation. In addition, effects on cervical mucus reduce sperm penetration (**Grade B**).

Contraceptive Efficacy

10. Women should be advised of low failure rates for intrauterine contraception at 5 years use: less than 2% with TCu380A and TCu380S and less than 1% with the LNG-IUS (**Grade C**).
11. The TCu380S and the LNG-IUS are the most effective intrauterine devices available (**Grade A**).

Duration of Use

12. TCu380A and TCu380S can remain in place for 10 years and other Cu-IUDs for 5 years (**Grade C**).
13. TCu380S is recommended as a first-choice Cu-IUD to minimise the established risks associated with reinsertion (**Grade C**).
14. After counselling (about declining fertility, risks associated with insertion and contraceptive efficacy) women who have a Cu-IUD inserted at the age of 40 years or over can retain the device for 1 year after the last menstrual period if aged over 50 years (or 2 years if under 50 years) or until contraception is no longer required (**Grade C**).
15. Women should be informed that the LNG-IUS is licensed for 5 years of use as a contraceptive (**Grade C**).
16. Women who have the LNG-IUS inserted at the age of 45 years or over for contraception can retain the device until the menopause is confirmed or until contraception is no longer required (**Good Practice Point**).

Perforation

17. Women should be informed that uterine perforation associated with intrauterine contraception is up to 2 per 1000 insertions (**Grade B**).

Expulsion

18. The risk of expulsion with intrauterine contraception is around 1 in 20 and is most common in the first year of use, particularly within 3 months of insertion (**Grade B**).
19. In general, there are no differences in the rates of expulsion between different Cu-IUDs and between Cu-IUDs and the LNG-IUS (**Grade A**).

Risk of Ectopic Pregnancy

20. Women should be informed that the overall risk of ectopic pregnancy is reduced with use of intrauterine contraception when compared to using no contraception and no particular device is associated with a lower rate of ectopic pregnancy (**Grade A**).

Return to Fertility

21. Women may be advised that there is no delay in return to fertility after removal of intrauterine contraception (**Grade B**).

Pelvic Infection

22. Women should be advised there may be an increased risk of pelvic infection in the 20 days following insertion of intrauterine contraception but the risk is the same as the non-IUD-using population thereafter (**Grade B**).

Bleeding Patterns and Pain

23. Women should be informed that spotting, light bleeding, heavier or prolonged bleeding are common in the first 3 to 6 months of Cu-IUD use (**Grade C**).
24. Women can be informed that discontinuation due to bleeding and pain are similar for different types of framed and unframed Cu-IUDs (**Grade A**).
25. Women should be informed that irregular bleeding and spotting is common in the first 6 months after insertion of the LNG-IUS but by 1 year amenorrhoea or light bleeding is usual (**Grade B**).

Hormonal Side Effects

26. Women considering the LNG-IUS can be informed that systemic absorption of progestogen occurs; however, rates of discontinuation due to side effects (such as acne and headache) are not significantly different from Cu-IUD users (**Grade C**).

Ovarian Cysts

27. Women may be informed that although ovarian cysts may occur when using the LNG-IUS they are rarely a clinical problem (**Grade B**).

Non-Contraceptive Benefits

28. The LNG-IUS can be used in the management of idiopathic menorrhagia and/or to provide endometrial protection in conjunction with estrogen therapy (**Grade B**).

Information About the Insertion Procedure

29. Discomfort during and/or after intrauterine contraceptive insertion should be discussed with women during counselling (**Good Practice Point**).

Choice of Device

30. Health care professionals should enable women to choose an intrauterine method based on medical eligibility and the woman's preference (**Good Practice Point**).
31. If women choose a Cu-IUD the TCu380S is recommended as it is the most effective and has the longest duration of use (**Grade A**).

When Can Intrauterine Contraception Be Safely Inserted?

32. A Cu-IUD can be inserted at any time in the menstrual cycle if it is reasonably certain the woman is not pregnant (**Grade C**). See table below.
33. The LNG-IUS can be inserted at any time in the menstrual cycle if it is reasonably certain the woman is not pregnant and the clinician is reasonably certain there has been no risk of conception (**Good Practice Point**).
34. After counselling, and when intrauterine contraception is the preferred method, it may be inserted by an experienced clinician any time after abortion if there is no suspicion that the pregnancy is ongoing (**Good Practice Point**).

Table. Recommendations for Timing Insertion of Intrauterine Contraception as a Long-term Contraceptive Option

Circumstances When Intrauterine Contraception Can Be Inserted	Recommendations for Timing of Insertion
In all circumstances	A Cu-IUD can be inserted at *any time in the menstrual cycle* if it is reasonably certain[a] the woman is not pregnant. A Cu-IUD is effective immediately The LNG-IUS can be inserted at *any time in the menstrual cycle* if it is reasonably certain[a] the woman is not pregnant and the clinician is reasonably certain there is no risk of conception. Condoms or abstinence should be advised for 7 days after inserting the LNG-IUS unless inserted in the first 7 days of the cycle
Postpartum *(including post-Caesarean section and breastfeeding)*	Insert from 4 weeks postpartum as above
Following abortion	Ideally insert at the time of a first- or second-trimester surgical abortion for

Circumstances When Intrauterine Contraception Can Be Inserted	Recommendations for Timing of Insertion
	immediate contraceptive effect Following medical or surgical abortion ideally insert within the first 48 hours or delay until 4 weeks postpartum. However, waiting until 4 or more weeks post-termination may put women at risk of pregnancy. After counselling and when intrauterine contraception is the preferred method it can be inserted by an *experienced clinician at any time post-abortion* if there is no concern that the pregnancy is ongoing
Switching from another method of contraception	Intrauterine contraception can be inserted at any time if another method of contraception has been used consistently and correctly. Insert any time if it is reasonably certain[a] that the woman is not pregnant. There is no need to wait for the next menstrual period or withdrawal bleed A Cu-IUD is effective immediately. Condoms or abstinence may need to be advised for 7 days after inserting the LNG-IUS unless the current contraceptive method is

Circumstances When Intrauterine Contraception Can Be Inserted	Recommendations for Timing of Insertion
	still effective (e.g., <12 weeks since last progestogen-only injection; within 3 years of insertion of a subdermal implant; no later than Day 1 of the hormone-free interval for pills or patch)

[a]A provider can be reasonably certain a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any of the following criteria:

- Has not had intercourse since last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is within the first 7 days after normal menses
- Is within the first 7 days post-abortion or miscarriage
- Is fully or nearly fully breastfeeding, amenorrhoeic, and less than 6 months postpartum.

Cu-IUD, copper intrauterine device; LNG-IUS, levonorgestrel intrauterine system.

How Can Safe Insertion of Intrauterine Contraception Be facilitated?

Training

35. Clinicians who insert intrauterine contraception should be appropriately trained, maintain competence and attend regular updates in dealing with emergencies (**Grade C**).

Informed Consent

36. Informed consent should be given by women prior to insertion of intrauterine contraception (**Good Practice Point**).

Assistants and Chaperones

37. An appropriate trained assistant who can monitor the condition of the patient and assist in an emergency should be present during insertion of intrauterine contraception (**Good Practice Point**).

Pain Relief

38. The need for pain relief during insertion of intrauterine contraception should be discussed with the woman in advance and administered when appropriate (**Good Practice Point**).

Emergency Management for Problems at Intrauterine Device Insertion

39. Emergency equipment must be available in all settings where intrauterine contraception is being inserted and local referral protocols must be in place for women who require further medical input (**Grade C**).

Note: See Table 5 in the original guideline document 'Emergencies and insertion of intrauterine contraception: resuscitation measures and contents of an emergency pack'.

Practical Procedures for Intrauterine Insertions

Bimanual Examination

40. A bimanual pelvic examination should be performed on all women before inserting intrauterine contraception (**Grade C**).

Measurement of Pulse Rate and Blood Pressure

41. Pulse rate and blood pressure should be assessed and documented when appropriate and depending on the clinical situation when inserting intrauterine contraception (**Good Practice Point**).

Cervical Cleansing

42. Cleansing the ectocervix prior to insertion of intrauterine contraception has no proven benefit (**Good Practice Point**).

Sterile Gloves

43. A 'no-touch' technique should be used when sounding the uterine cavity and inserting intrauterine contraception. If this technique is used then sterile gloves are not required (**Good Practice Point**).

Use of Forceps and Assessment of the Uterine Cavity

44. During insertion of intrauterine contraception clinicians should stabilise the cervix with forceps and assess the length of the uterine cavity to facilitate fundal placement and reduce the risk of perforation (**Grade C**).

Documentation

45. Documentation should be made in the case notes to record appropriate pre- and post-insertion counselling, the insertion procedure and the type of device inserted (**Grade C**).

Note: See Box 1 in the original guideline document for appropriate information to document when inserting intrauterine contraception.

What Information Should Be Given to Women About Ongoing Use of Intrauterine

Contraception and Follow-Up?

Information About the Device

46. Women should be given information (oral and written) about the device inserted and the expected duration of use (**Good Practice Point**).

Checking Threads and Device

47. Women should be offered instruction on how to check for the intrauterine contraceptive and its threads and advised that if they are unable to feel them it may be that the device has been expelled. Alternative contraception should then be used until they seek medical advice (**Good Practice Point**).

Reducing the Risk of STIs

48. If a woman chooses intrauterine contraception and is at higher risk of STIs (i.e., aged <25 years, or aged >25 years with a new sexual partner, or more than one partner in the last year, or if their regular partner has other partners) she should be advised to use condoms in addition to the intrauterine method (**Good Practice Point**).

Symptoms Requiring Medical Attention

49. Women should be advised to seek medical assistance at any time if they develop symptoms of pelvic infection, pain, persistent menstrual abnormalities, missed period, non-palpable threads or can feel the stem of the intrauterine device (**Grade C**).

Routine Follow-Up

50. A routine follow-up visit should be advised after the first menses following insertion of intrauterine contraception or 3 to 6 weeks later (**Grade C**).

Managing Problems Associated with Intrauterine Contraception

Recommendations and good practice points for managing problems associated with intrauterine contraception are summarised in the table below.

Table. Managing Common Problems Associated with Intrauterine Contraception

Problems Associated with Intrauterine Contraception	Management

Problems Associated with Intrauterine Contraception	Management
Suspected perforation at the time of insertion	The procedure should be stopped and vital signs (blood pressure and pulse rate) and level of discomfort monitored until stable An ultrasound scan and/or plain abdominal X-ray to locate the device if it has been left *in situ* should be arranged as soon as possible
'Lost threads'	Advise women to use another method (condoms or abstinence) until medical review. Consider the need for emergency hormonal contraception If no threads are seen and uterine placement of the intrauterine method cannot be confirmed clinically, an ultrasound scan should be arranged to locate the device and alternative contraception recommended until this information is available If an ultrasound scan cannot locate the intrauterine method and there is no definite evidence of expulsion, a plain abdominal X-ray should be arranged to identify an extrauterine device If the intrauterine method is not confirmed on an ultrasound scan

Problems Associated with Intrauterine Contraception	Management
	clinicians should not assume it has been expelled until a negative X-ray is obtained (unless the woman has witnessed expulsion) Hysteroscopy is not readily available in all settings but can be useful if the ultrasound scan is equivocal. Surgical retrieval of an extrauterine device is advised
Abnormal bleeding	Gynaecological pathology and infections should be excluded if abnormal bleeding persists beyond the first 6 months following insertion of intrauterine contraception Women using the LNG-IUS who present with a change in pattern of bleeding should be advised to return for further investigation to exclude infections, pregnancy and gynaecological pathology For women using a Cu-IUD, non-steroidal anti-inflammatory drugs can be used to treat spotting, light bleeding heavy or prolonged menstruation. In addition antifibrinolytics (such as tranexamic acid) may be used for heavy or prolonged menstruation

Problems Associated with Intrauterine Contraception	Management
Pregnancy	Most pregnancies in women using intrauterine contraception will be intrauterine but an ectopic pregnancy must be excluded Women who become pregnant with an intrauterine contraception *in situ* should be informed of the increased risks of second-trimester miscarriage, preterm delivery and infection if the intrauterine method is left *in situ*. Removal would reduce adverse outcomes but is associated with a small risk of miscarriage If the threads are visible, or can easily be retrieved from the endocervical canal, the intrauterine contraceptive should be removed up to 12 weeks' gestation If there is no evidence that the intrauterine method was expelled prior to pregnancy it should be sought at delivery or termination and, if not identified, a plain abdominal X-ray should be arranged to determine if the intrauterine method is extrauterine
Suspected	For women using

Problems Associated with Intrauterine Contraception	Management
pelvic infection	intrauterine contraception with symptoms and signs suggestive of pelvic infection appropriate antibiotics should be started. There is no need to remove the intrauterine method unless symptoms fail to resolve within the following 72 hours or unless the woman wishes removal All women with confirmed or suspected PID should be followed up to ensure: resolution of symptoms and signs, their partner has also been treated when appropriate, completion of the course of antibiotics, STI risk assessment, counselling regarding safer sex and partner notification
Presence of actinomyces-like organisms (ALO)	Intrauterine contraceptive users with ALO detected on a swab who have no symptoms should be advised there is no reason to remove the intrauterine method unless signs or symptoms of infection occur. There is no indication for follow-up screening. If symptoms of pelvic pain occur women should be advised to seek medical advice. Other causes of infection (in particular STIs) should be

Problems Associated with Intrauterine Contraception	Management
	considered and it may be appropriate to remove the intrauterine method

Timing the Removal of Intrauterine Contraception

Advice regarding the removal of intrauterine contraception varies depending on the reason for removal and if there is any wish to continue to avoid pregnancy (See Table below).

Table. Recommendations for Removal of Intrauterine Contraception

Reason for Removal	Recommendations for Removal
For a planned pregnancy	Remove at any time in the menstrual cycle (offer pre-pregnancy advice regarding folic acid, rubella immunity)
When removal and replacement is at the end of the licensed duration of use	Remove at any time in the menstrual cycle. If pregnancy is to be avoided remove in the first few days after the onset of menstruation or advise condoms or abstinence from sexual intercourse for at least 7 days before the procedure in case re-insertion is not possible
When removal and replacement is outside the licensed duration of use	**Postmenopausal Removal** A Cu-IUD inserted at or after the age of 40 years can be retained until 1 year

Reason for Removal	Recommendations for Removal
	after the LMP if this occurs when the woman is over the age of 50 years A Cu-IUD inserted at or after the age of 40 years can retained until after the LMP but if this occurs under the age of 50 years the device should be retained for a further 2 years The LNG-IUS can continue to be used as contraception for 7 years if inserted at or after the age of 45 years. Use beyond this time can be discussed with individual patients **Management of Menorrhagia** If the LNG-IUS is being used in the management of menorrhagia (and not for contraception or with estrogen-replacement therapy) it can be retained beyond the 5-year licensed duration of use if bleeding patterns are acceptable

Definitions:

Grades of Recommendations

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point: Where no evidence exists but where best practice is based on the clinical experience of the Multidisciplinary Group

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of a copper intrauterine device for contraception

POTENTIAL HARMS

- Discomfort or pain during and after insertion of intrauterine contraceptive device
- Emergencies that may arise during insertion of intrauterine contraceptive device (i.e., instrumentation of the cervix or uterus, insertion of the device or collapse where there is an anaphylactic response to medications or provoking agents such as latex gloves or local anaesthetic)
- The rate of uterine perforation associated with intrauterine contraceptive use is low (0 to 2.3 per 1000 insertions)
- Expulsion of intrauterine contraceptive device
- Pelvic infection in the 20 days following insertion
- Irregular bleeding, spotting, light bleeding, or heavier or prolonged bleeding common in first 3 to 6 months after insertion of copper-bearing intrauterine device
- Irregular bleeding and spotting common 6 months after insertion of levonorgestrel-releasing intrauterine system (LNG-IUS)
- Rate of removal of intrauterine contraceptive device due to side effects
- Ovarian cysts (with LNG-IUS)
- Hormonal side effects of LNG-IUS
- Loss of threads
- Need for removal and reinsertion
- Failure of intrauterine contraceptive device, unintended pregnancy

CONTRAINDICATIONS

CONTRAINDICATIONS

Risks outweigh benefits:

- Between 48 hours and <4 weeks postpartum
- Current venous thromboembolism (on anticoagulants)
- Initiation of method in women with ovarian cancer
- Continuation of intrauterine methods in women with known pelvic tuberculosis

Unacceptable risks:

- Pregnancy, puerperal sepsis, septic abortion
- *Initiation* of the method in women with unexplained vaginal bleeding
- Gestational trophoblastic neoplasia when serum hCG concentrations are abnormal
- Initiation of the method in women with cervical cancer awaiting treatment or with endometrial cancer
- Uterine fibroids or uterine anatomical abnormalities distorting the uterine cavity
- Initiation of intrauterine methods in women with current pelvic inflammatory disease or purulent cervicitis
- Initiation of intrauterine methods in women with known pelvic tuberculosis

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This document is not intended to serve alone as a standard of medical care, as this should be determined individually based on available clinical information.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. Intrauterine contraception. London (UK): Faculty of Sexual and Reproductive Healthcare; 2007 Nov. 21 p. [133 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Nov

GUIDELINE DEVELOPER(S)

Faculty of Sexual and Reproductive Healthcare - Professional Association

SOURCE(S) OF FUNDING

Faculty of Sexual and Reproductive Healthcare

GUIDELINE COMMITTEE

Clinical Effectiveness Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Clinical Effectiveness Unit (CEU): Dr Susan Brechin, (Unit Director); Ms Gillian Stephen and Ms Lisa Allerton, (Research Assistants)on behalf of Faculty of Sexual and Reproductive Healthcare (FSRH) with a multidisciplinary group of health professionals comprising: Dr Urszula Bankowska (Consultant and Associate Director of Governance and Quality, The Sandyford Initiative, Glasgow); Dr Jo Bibby (FSRH Council Member and Consultant in Contraceptive and Sexual Health, Swansea NHS Trust); Dr Ellie Birtley (Associate Specialist in Contraception and

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Sexual and Reproductive Healthcare Web site.

Print copies: Available from the Faculty of Sexual and Reproductive Healthcare, 27 Sussex Place, Regent's Park, London NW1 4RG

AVAILABILITY OF COMPANION DOCUMENTS

Discussion points and questions for intrauterine contraception developed by the Faculty of Sexual and Reproductive Healthcare are available at the end of the original guideline document.

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Sexual & and Reproductive Healthcare Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on May 16, 2008.

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Date Modified: 9/22/2008