IUD placement as a barrier to use

Intrauterine devices (IUDs), which comprises both levonorgestrel-releasing and copper-bearing IUDs, **provide highly effective, environmentally friendly, long-acting contraception without relying on user compliance.**[1–4] However, concerns regarding placement pain and ease of placement are common among both healthcare providers (HCPs) and women.[5–10] There is a common belief that IUDs are not suitable for young or nulligravid women.[5,6,10,11] Furthermore, many HCPs report discomfort with carrying out the IUD placement procedure due to their limited experience and/or training.[10,11]

In most cases, women (even younger and/or nulligravid women) actually report no more than mild pain and HCPs report that placement is easy.[12–15] Although the pain during IUD placement is generally low, it is vital that we do not dismiss the concerns women have about placement or their valid experiences of discomfort.

Women's voices

"I have had four IUDs in total, after having children. For me, I didn't experience much pain at all. My practitioners were very good. They were reassuring and thoroughly explained the placement, both before and during the procedure. I was also recommended to take NSAIDs after the procedure, which reduced the discomfort. I think it helped that I went into the placements relaxed, without much anxiety. This was partly because it was my personal doctor who carried out my first IUD placement. I found it comforting to have a doctor who knew my history, was experienced, and had carried out my previous gynecological tests."

Anonymous woman 1

"I've had five IUDs in total so I have plenty of experience with IUD placement! My first placement was the least positive of my experiences. The practitioner was not welcoming or reassuring. The room and equipment were cold so I felt very tense. The last two IUD placements I had were completely different. The room was warm and comfortable, and the practitioners were knowledgeable. They didn't rush the procedure and explained each step as the placement was being carried out.

As I tend to experience more pain than the typical woman during IUD placement, I liked that they didn't minimise this and instead recognised that it would cause discomfort, but reassured me they would do everything they could to reduce this. They provided me with a local anesthetic injection, which helped a lot. Having a second practitioner in the room to distract me also helped.

Despite experiencing some pain, these positive experiences made a huge difference and I highly recommend IUDs for other women!"

Anonymous woman 2

Difficult placement

Some women may experience higher levels of pain and/or difficult placement.[12–15] If you are experiencing a difficult placement with your patient, **reassure your patient and be prepared to stop the procedure**.

Use of an ultrasound is only recommended to confirm the position of the uterus and ensure no creation of a false passage.

You may opt to delay placement for another time (ideally between days 12–15 of the menstrual cycle).

Cervical priming with misoprostol and intracervical or paracervical blocks have limited evidence of efficacy, but may be helpful for more difficult placements.[16–18] General anaesthesia should be a last resort.

Women with a higher likelihood of a difficult placement:

- High anxiety
- Nulligravid
- Previous elective Caesarean delivery
- Very retroflexed or anteflexed uterus
- Prior surgical procedures on the cervix
- Adolescents
- Difficult and/or painful uterine sounding

Possible causes of pain during IUD placement:

- Fear of pain and anxiety
- Grasping cervix during uterus stabilisation
- Pulling uterus while stretching flexion angle
- Pushing inserter against fundus
- Touching and grasping uterine walls
- Stiff cervix and cervical dilation procedure
- Creating a false passage during insertion
- Forcing the IUD into the intended position and/or shape
- Working at excessive speed and ignoring the patient

Conclusions

- Improving the IUD placement experience can even help women who experience little or no pain.
- A minority of women experience significant pain; their concerns should be validated and taken seriously.
- Pain and anxiety can generally be minimised by effective pre-placement counselling, and reassurance and/or distraction during placement.
- The importance of 'verbal anaesthesia' should not be underestimated.

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WHA contributing members:
Luis Bahamondes, Amanda Black, Dustin Costescu, Kristina Gemzell Danielsson

This document was funded by Bayer
PP-M_IUS_20-ALL-0019-1 04/2024
PP-M_IUS_20-ES-0002-1 04/2024

Women's Health Academy
Changing Paradigms

Improving comfort during IUD placement

Knowledge • Collaboration • Communication

How can I improve the IUD placement experience for women?

Confidence and comfort with carrying out the IUD placement procedure are key to ensuring a favourable experience for women. We have compiled this guidance using useful resources and tools,[16–18] along with tips from our own personal practice experience, to give recommendations on how to provide the best possible placement experience for women.

Pre-placement guidance: preparing women

Preparing women for a positive placement experience should start from the moment they have chosen an IUD. You should explain what to expect during and after the procedure to reassure and set their expectations. Key points include:

- The placement procedure is a short process
- Although everyone's placement experience is different, most women experience little to no pain
- Many women find it comforting to bring a person with them for support
- Post-placement discomfort and cramping is normal and may feel similar to period cramps
- The woman is in control – they can ask to stop or pause at any time

Letting women hold an IUD can be reassuring - they will see that the IUD is likely much smaller than they anticipated.

Women can take steps to prepare themselves before the procedure:

- Wear something comfortable
- Have a light meal/snack beforehand
- Come with an empty bladder
- Bring something (e.g. music) to distract themselves

Pre-placement guidance: setting the scene

- Ensure that all necessary equipment for placement is available at hand.
- Try to make the room for the procedure as comfortable as possible. Set the thermostat to a mild temperature – avoid the room being too hot or too cold if possible.

Pre-placement intracervical or paracervical block may help to reduce IUD placement pain, however, there is little evidence on its efficacy from randomised studies in routine use.[16]

Although not evidence-based, taking an NSAID 1–2 hours before placement may have a placebo effect in minimising pain.

Preparing your patient: explain what to expect during the procedure.

'For some women, placement can hurt more than others. However, placement takes less than 5 minutes and provides years of birth control.'

'For most women, placement can cause a little pain, a bit like period pain, which quickly passes.'

During placement

Explain in simple terms which step of the procedure you will carry out next. Be aware that certain steps may cause more discomfort than others – describing what you are doing and what it may feel like to the patient can help.

Listen to your patient to see if they have any concerns. Be prepared to **individualise and adapt how you talk to each woman** as each person will have different factors that increase or decrease their comfort or anxiety.

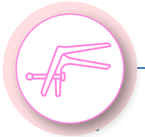
Patient anxiety may increase with the duration of the procedure.

'Now I am going to measure your uterus. This instrument may feel cold.'

'We're almost done now, I am about to place the IUD. You may feel a short cramp-like pain.'

Anxiety can have a large impact on placement pain – women who are more anxious and anticipate higher pain subsequently rate their pain as higher.[7,19,20]

Intra-cervical injection of local anaesthetic gel may make cannulation of the cervical canal more comfortable, but there is limited clinical evidence.



Setting the scene: ensure the room is comfortable and all equipment is at hand.

During placement: explain each step as you carry it out and listen to your patient. Use verbal anaesthesia or a hot water bottle to redirect your patient's focus.

Post-placement: advise on what to expect post-placement and provide symptomatic relief (e.g. NSAIDs and a hot water bottle).

Follow-up: expain that a follow-up appointment can be organised if your patient desires.

'Verbal anaesthesia', i.e. using distraction techniques to take your patient's focus away from the procedure and reduce their anxiety, can lead to a large reduction in pain.[17,21] Distraction techniques may include talking to your patient (or asking their support partner or an auxiliary healthcare provider to talk to them) about unrelated topics.

A hot water bottle placed at the lower part of the abdomen can also provide a comforting sensation and redirect your patient's focus.

Tips for reducing discomfort:

- Smaller IUDs are generally associated with less pain and greater placement ease.[12,13,22] You may wish to recommend these, particularly for nervous, younger, and/or nulliparous women.
- Placement may be easier during days 12–15 of the menstrual cycle.
- Use of a smaller speculum can reduce discomfort.
- Routine use of ultrasound is not necessary but, if available, can be helpful to guide placement.

Post-placement

It is not unusual for women to experience some discomfort and cramping post-placement.

Reassure your patient of this, highlighting that this discomfort often lasts little more than a day.

After the procedure is over, your patient should remain lying down for a short period and then sit for a short period to allow any possible vasovagal effect to pass.

You should **offer your patient symptomatic relief/analgesia (NSAIDs)**. A hot water bottle may also be comforting.

Advise on what to expect in the days following the procedure so that they can spot any unusual symptoms. Unusual symptoms may include unexpected bleeding beyond the anticipated spotting, severe pain, prolonged pain, or IUD expulsion.

'You may feel some cramp-like pain (similar to what you would experience during your period), which often begins around one to two hours after getting your IUD placed.'

' The cramping often begins around one to two hours after getting your IUD placed and lasts for about a day.'

Follow-up

Assure your patient that they will be able to contact you if they have any concerns, including regarding cramping and/or discomfort. If your patient desires, a **follow-up appointment may be organised**.

Habitually, one follow-up visit between three and five months after device placement is appropriate because more than 50% of expulsions occur within this timeframe.[23]

If your patient is experiencing any symptoms of clinical concern, take appropriate steps (e.g. physical examination and ultrasound) immediately to exclude uterine perforation.

Perimenopause counselling should encompass **three** aspects:

preparation, recognition, and early intervention…

Improving perimenopause counselling

Effective counselling is the basis for effective treatment, so **educating all different HCPs is key**. Perimenopause management needs to be comprehensively integrated into medical curricula and residency training across a range of specialties.

Perimenopause management requires a multidisciplinary approach; HCPs should not hesitate to refer patients to specialists if required. Often-neglected aspects of perimenopause support, such as pregnancy prevention and menstrual bleeding and fertility discussions need to be more frequently addressed in counselling.

Perimenopause counselling should encompass three aspects: preparation, recognition, and early intervention. **Women should be prepared and educated on what to expect during their menopausal transition** and feel encouraged to approach their HCP for treatment if they experience any bothersome symptoms and/or desire prophylactic treatment.

HCPs should aim to prevent symptoms from becoming bothersome where possible. In addition, gynecological and non-gynecological cancers have their peak incidence during perimenopause and the first years post-menopause. Therefore, preventative measures should be promoted to reduce the incidence of invasive tumors.[6,12]

Women should be equipped with the knowledge that, while perimenopausal symptoms are common, these symptoms do not have to be suffered in silence – **there are treatment options available**.

As symptoms during the menopausal transition are wide-ranging and each woman's experience of perimenopause is unique, counselling for women in perimenopause should be individually tailored, with shared decision-making so that the woman herself is a key participant in her menopausal management journey.

How can HCPs improve our patient experiences?

As a woman who has had both negative and positive experiences during perimenopause with HCPs, establishing a relationship between the HCP and patient is key. HCPs should treat their patient as partners in care and as the expert of their own body. There needs to be an open dialogue, avoiding rushing the patient. Patient context (socio-politically) and personal background are relevant and important. Language has to be inclusive and the patient has to understand what the doctor is saying. Discussions and management plans should be holistic and patient-centered.

Key takeaways

- Perimenopause is a life stage that all women go through, however it can be a challenging period for some women.
- Counselling and management strategies should be individually-tailored, comprehensive, and multidisciplinary.
- Patient engagement in decision making is a must.
- **It is our duty to raise awareness among both women and HCPs and empower women to seek care.**

Women's Health Academy

- The Women's Health Academy is a network of women's health clinicians and academic experts committed to establishing best practice in diagnosis and management in women's healthcare.
- This is the first in our series of opinion pieces, with the next piece on practical tips for multidisciplinary counselling on perimenopause.

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WHA contributing members:

Virginia Abalos; Luis Bahamondes; Johannes Bitzer; Amanda Black; Dustin Costescu; Kristina Gemzell Danielsson; Giovanni Grandi; Oskari Heikinheimo; Ali Kubba; Agnaldo Lopes da Silva Filho; Rossella Nappi; Anita Nelson; Nicholas Panay; Carolina Sales Vieira; Sukbhir Sony Singh.

Intended for HCPs only

PP-M_ELINZA-ES-0001-1 04/2024
PP-M_ELINZA-ES-0002-1 04/2024

Women's Health Academy
Changing Paradigms

Perimenopause:

Focus on an important and often neglected life stage

Knowledge • Collaboration • Communication

Featuring
Omisade Burney-Scott

My experience of perimenopause and what I wish I'd known…

Perimenopause is a normal and important life stage that all women go through and can span many years. However, a fierce combination of knowledge gaps, societal influences, and social stigma makes perimenopause a poorly understood and rarely discussed period in a woman's life, both for healthcare practitioners (HCPs) and women themselves. This lack of understanding means that many women do not receive beneficial care, negatively affecting their quality of life and overall health.[1–3]

As women's health is often defined by reproduction, perimenopause is often approached as a period of loss, rather than achievement of what has been accomplished and what is to come. **HCPs can help to change this into a period of empowerment and control for women.**[1–3]

Each woman's experience of the menopausal transition is unique. Some women experience few or mild symptoms, while others suffer multiple severe symptoms that can affect their quality of life.[2] It is important that women are aware of the variety of available management options to suit their individual needs.

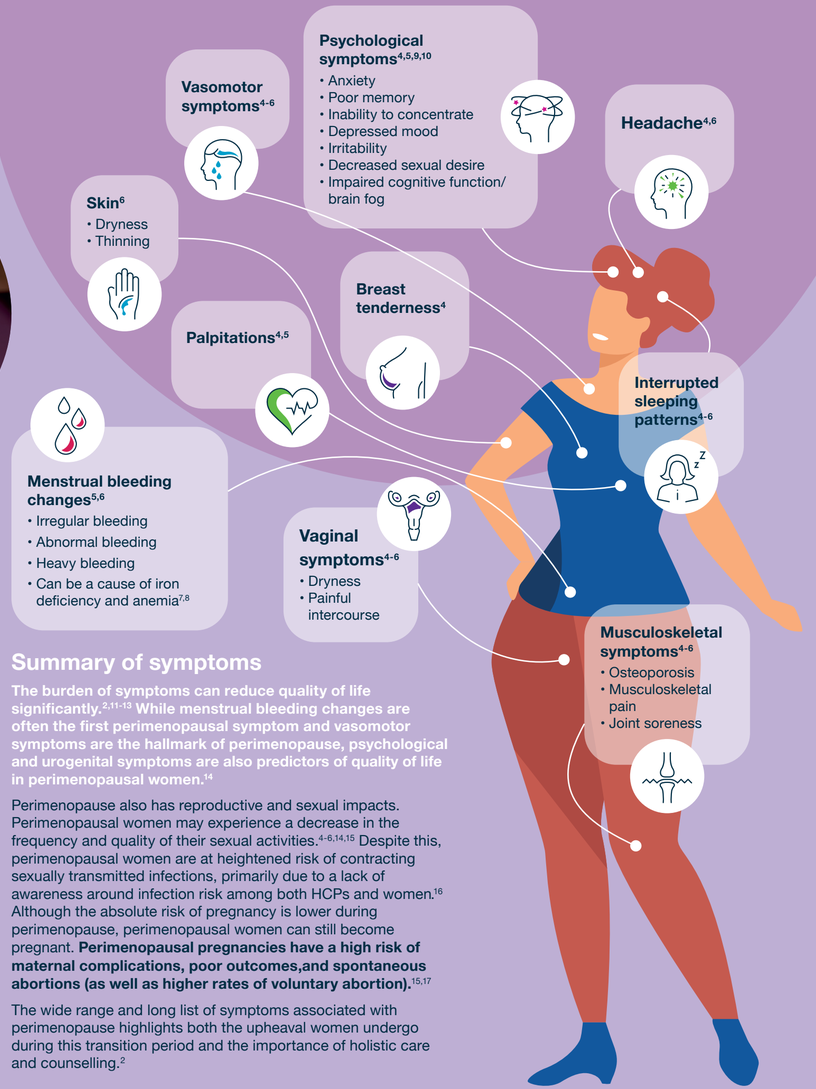
Here we discuss the unmet needs surrounding perimenopause and what we as HCPs can do to address these unmet needs and improve menopausal counselling as a whole.

My experience of perimenopause and what I wish I'd known

Omisade Burney-Scott

Despite working in Reproductive Justice, it wasn't until I entered perimenopause myself that I really learned about this life stage. There is no preparation – support starts when perimenopause starts rather than before. In fact, I hadn't even heard the term 'perimenopause' until I experienced an unexpected pregnancy and subsequent miscarriage when I was 40. This traumatic experience was made worse by the insensitive, condescending and dismissive attitude of the doctor who provided cover for my regular HCP. I did not realise until this point how complicated ageing and the menopausal transition are, particularly for marginalized groups who get pushed further to the margins. There is also a sense that older women are viewed as lesser. I am fortunate to have a team of regular HCPs around me with whom I have built a rapport of mutual trust and respect. These relationships with my HCPs and my network of friends and family have proved to be critical supports for me during my menopausal transition.

The menopausal transition reframes your understanding of your body and is experienced differently by each individual. For me, there was a long period where I had no symptoms, followed by an 18-month period of insomnia, brain fog, weight fluctuations and vasomotor symptoms. As a postmenopausal woman, some symptoms such as insomnia and brain fog lingered, and I was diagnosed with clinical depression associated with fatigue. I was able to develop a holistic management plan with my HCPs for both my peri- and postmenopausal symptoms, including complementary and alternative therapies. My HCPs helped guide me through my menopausal transition by keeping myself and my personhood at the center of discussion.



Summary of symptoms

The burden of symptoms can reduce quality of life significantly.[2,11-13] While menstrual bleeding changes are often the first perimenopausal symptom and vasomotor symptoms are the hallmark of perimenopause, psychological and urogenital symptoms are also predictors of quality of life in perimenopausal women.[14]

Perimenopause also has reproductive and sexual impacts. Perimenopausal women may experience a decrease in the frequency and quality of their sexual activities.[4-6,14,15] Despite this, perimenopausal women are at heightened risk of contracting sexually transmitted infections, primarily due to a lack of awareness around infection risk among both HCPs and women.[16] Although the absolute risk of pregnancy is lower during perimenopause, perimenopausal women can still become pregnant. **Perimenopausal pregnancies have a high risk of maternal complications, poor outcomes,and spontaneous abortions (as well as higher rates of voluntary abortion).**[15,17]

The wide range and long list of symptoms associated with perimenopause highlights both the upheaval women undergo during this transition period and the importance of holistic care and counselling.[2]

Woman's perspective

Recent surveys have found that most women feel ill-prepared and uninformed about the menopausal transition.[1,3] Women may be unaware that their symptoms are related to perimenopause, may not wish to interfere with a natural process, or may not know what treatment options are available.[2,3,18] Women may also be reluctant to seek help due to social stigma and embarrassment.

Many women have reported that their concerns were dismissed by HCPs as a natural process not requiring treatment and received little information from HCPs regarding available treatments.[2] Aversion to hormone therapy is also widespread among women, primarily due to concerns about side effects, long-term risks, and the perception that perimenopause is natural and should not be interfered with.[11,18,19]

Women often rely on non-professional sources of information, leading them to use alternative non-prescription treatments as a first approach to manage perimenopausal symptoms.[11,20] Women believe these alternative therapies to be natural and safe with few or mild side effects, despite little to no clinical research into their efficacy or safety.[20] Some women feel that they cannot rely on HCP advice on whether a (sometimes costly) treatment option is tolerable or not, and while some will provide relief, some do not.

HCP's perspective

Perimenopausal symptoms can be far more varied than typically communicated to HCPs in their training. To provide effective and holistic perimenopause support, a multisystemic and multidisciplinary approach to symptom management is needed. The limited training provided to HCPs across specialties, and limited cross-speciality cohesion, means that menopause counselling frequently fails to communicate key holistic healthcare advice to women in and approaching perimenopause.[1] Aspects such as sexual and reproductive health care are often absent from counselling conversations and treatment plans.

Many HCPs (even gynecologists) admit a lack of knowledge and training relating to perimenopausal symptom management and do not feel confident counselling women during this transition.[1,2] Limited and inconsistent evidence is a key barrier to improving counselling, particularly for individualized care recommendations.[6,21-23] Furthermore, **HCPs are not immune to misconceptions and misinformation;** they overestimate the risks and contraindications of hormone therapies, **underestimate the impact or severity of perimenopausal symptoms**, and rarely are able to offer holistic support.[1,11]

Women are often provided with inappropriate counselling and treatment, or no treatment, due to a focus on mitigating symptoms rather than a holistic package of support.[11,18] These **knowledge gaps and misconceptions may have a significant impact on women; women may feel unheard and dismissed, go untreated, or receive inappropriate treatment** that does not address the underlying symptoms or wider range of symptoms.[2,11]