

Case-based Curriculum for LARC Eligibility

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Rita



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Case 1: Nulliparous teen

Rita is 16 years old and has never been pregnant. She comes in requesting the LNG-IUS (levonorgestrel intrauterine system; Mirena[®], Skyla[®], Liletta[®], Kyleena[®]) because a friend has it and she likes the idea of not having to hide pills or other methods from her mother. She reports that she has had 3 partners in the past and right now is thinking about starting to have sex with her boyfriend of 1 month.

Questions:

1. Do you think this patient is a good candidate for an IUD? Why or why not?
2. What other questions would you want to ask this patient in order to decide whether the LNG-IUS is a good option for her?
3. What screenings would be needed for this patient prior to IUD insertion?

Key points:

- This patient seems like a good candidate for an IUD.
- No extra screening is needed because she is a teen – just pregnancy testing and GC/C screening at time of insertion.
- There is no concern related to her 3 previous partners. Teens and adults often present for IUDs having had many partners in the past. Only concern is current STI risk.
- In IUD counseling with all patients, it's important to ask them if they want to have a period or not. This is particularly important with teens who are accessing the method without their mother's (or other family members') knowledge, because their mothers may be checking to see if they get their period. You can ask:
 - Does your mom check on whether you get your period, or budget for tampons/pads so she would notice if your period is lighter or goes away?
 - The hormonal IUD will make your period irregular or you may not have a period at all– will that be an issue in your household?
- Teens may feel it is “unclean” or unnatural” not to have a period, so reassuring them may help them feel more comfortable with the method.
- Insertion procedure is the same for a teen, and we don't anticipate a more complex procedure.
- This could be her first pelvic exam, so it's important to be particularly aware of helping her through that experience.
 - If a teen is undecided about her method, it may be a counseling point that the implant is a long-term method that would not require a pelvic exam.
- State laws vary widely regarding minors' ability to consent to contraceptive care. To learn about laws in your state, refer to: http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf
- For more information about LARC use in adolescents, refer to the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on this topic: [https://www.acog.org/Resources And Publications/Committee Opinions/Committee on Adolescent Health Care/Adolescents and Long-Acting Reversible Contraception](https://www.acog.org/Resources%20And%20Publications/Committee%20Opinions/Committee%20on%20Adolescent%20Health%20Care/Adolescents%20and%20Long-Acting%20Reversible%20Contraception)

Janie



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Case 2: History of infection

Janie is a 26-year-old who has had one pregnancy and would like an IUD. When asked for her history, she said a doctor had once told her she had an infection “down there” and she took antibiotics to treat it.

Questions:

1. Do you think this patient is a good candidate for an IUD today? Why or why not?
2. What other questions would you want to ask this patient?
3. What screenings would be needed for this patient prior to IUD insertion?
4. What if you are able to access Janie’s records, and learn that . . .
 - a. Janie’s infection was Chlamydia, six months ago?
 - b. Janie’s infection was PID, one year ago, and occurred after her pregnancy?
 - c. Janie’s infection was PID and occurred before her pregnancy?
 - d. Janie has a current, incidental diagnosis of Chlamydia from another visit, a few days ago?

Key points:

- Note that it's not clear in this example what kind of infection she had – it could have been yeast, Chlamydia, bacterial vaginosis, or PID. It is common that a patient may not be able to provide more information about this.
 - Yeast infection or BV are not contraindications to IUD insertion.
- In either case, the most relevant question is whether or not she currently has an infection.
 - Her STI history may suggest that she is in a higher risk category for STIs, however, it is only relevant in terms of risk stratification to understand the risk of her currently being infected, because known current infection is a contraindication
 - Purulent cervical discharge (this is uncommon), or current PID is a contraindication for IUD insertion.
- It would be good to find out how long ago the infection was – refer to chart on next page.
- Note that the current recommendation, if there are no STI-related restrictions, is to screen the patient for gonorrhea/Chlamydia at the same visit as the insertion. If the test comes back positive, treat the infection while leaving the IUD in place.
- It is not necessary to wait for a negative screen in order to insert the IUD, there is no reason to delay insertion for this reason if a patient is asymptomatic and has no recent history of STI.
- It is possible that the patient could contract gonorrhea or Chlamydia in the interim period between providing the sample and returning for the insertion. Thus, it is better to screen and insert the IUD on the same day, and treat the infection with the IUD in place if the test comes back positive.

Table 1: IUD Eligibility Criteria for History of STI or PID

	GC/Chlamydia	PID
No GC/C history; no current symptoms	Screen and insert (Category 1).	
Had a pregnancy after the infection	Screen and insert (Category 1).	
Infection was more than 3 months ago, no pregnancy since infection	Screen and insert (Category 1).	Screen and insert (Category 2).
Recent history of . . .	If test is negative after treatment, screen and insert	No guidelines available.
Recent positive lab result or diagnosis	If most recent GC/C lab result is positive, insertion is contraindicated; treat the STI, offer a bridge method, and have the patient return for insertion. Screen and insert on that visit.	Contraindicated – offer a bridge method and have the patient return later for insertion.
Purulent cervicitis at time of insertion	Contraindicated – offer a bridge method and have the patient return later for insertion. (This condition is unusual.)	

Source: CDC Selected Practice Recommendations for Contraceptive Use, 2016 and United States Medical Eligibility Criteria for Contraceptive Use (CDC, upd. 7/2016).

Medical Eligibility Categories:

Category 1: No restriction (method can be used)

Category 2: Advantages generally outweigh theoretical or proven risks

Category 3: Theoretical or proven risks usually outweigh the advantages

Category 4: Unacceptable health risk (method not to be used)

Haley



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Case 3: Ruling out early pregnancy

Haley is a 22-year-old presenting for an IUD. She and her boyfriend have been using condoms inconsistently and she last had sex 3 days ago, without a condom. Her LMP was two weeks ago, and she has a negative pregnancy test today.

Questions:

1. Do you think this patient is a good candidate for an IUD today? Why or why not?
2. What other questions would you want to ask this patient?
3. What if . . .
 - a. Haley tells you she has used condoms all of the other times she had sex in the past 10 days?
 - b. After counseling about the two IUDs, Haley is not interested in the copper IUD and only wants the LNG-IUS?

Key points:

- IUD insertion when a woman is pregnant may increase the risk of infection and miscarriage/bleeding, so you must be reasonably certain a patient is not pregnant before inserting an IUD.
- The urine pregnancy test generally becomes positive 10 days after the patient becomes pregnant. If unprotected sex only happened more than 10 days ago, we can rule out pregnancy based on the pregnancy test, however, if it happened in the past 10 days, there may be an early pregnancy that cannot be picked up by the test.
- Thus, if the patient has had unprotected sex 6-10 days ago, we cannot be sure that she is not pregnant and thus cannot insert either IUD today.
- If she had unprotected sex *only in the last 5 days*:
 - Can provide a copper IUD, which would also be the most effective emergency contraception for her.
 - If the patient does not want the copper IUD, and only wants the LNG-IUS:
 - Important to discuss with her why she prefers the LNG-IUS over the copper IUD; perhaps there are some myths to dispel.
 - Give ella® (if available) or progestin emergency contraception (Plan B One-Step®, Next Choice®) today, plus bridge method, and she can return in 2 weeks for repeat pregnancy test and LNG-IUS insertion.
 - Bridge methods: Implant or depo shot are not a problem in the window period, because they do not harm the pregnancy and only risk delaying pregnancy diagnosis, whereas an IUD in a pregnant uterus carries a risk of infection.
- Remember to counsel about backup contraceptive use with the LNG-IUS – generally condom for 7 days

Table 2: Ruling Out Early Pregnancy

Reasonably certain a patient is not pregnant			
A patient has a negative HCG and . . .			
1. Has not had sex at all since LMP	2. Is using an effective contraceptive method (no unprotected sex)	3. Had unprotected sex since LMP, but not in the last 10 days	4. Had unprotected sex in last 5 days; NOT in last 6-10 days; wants copper IUD
Insert the IUD!			

Cannot be certain a patient is not pregnant	
A patient has a negative HCG and . . .	
1. Had unprotected sex 6-10 days ago	2. Had unprotected sex in last 5 days and wants LNG-IUS
Needs further counseling – provide bridge method to IUD	

Tiffany



Photo by [iphis](#)

Case 4: Recently given birth

Tiffany is a 30-year-old G1P1 who gave birth to a baby boy 5 weeks ago. She's here for her postpartum check-up and wants to start using an IUD.

Questions:

1. Do you think this patient is a good candidate for an IUD today? Why or why not?
2. What other questions would you want to ask this patient?
3. What if . . .
 - a. Tiffany is concerned about how the LNG-IUS will impact her ability to breastfeed?
 - b. Tiffany delivered via C-section?

Key points:

- Current CDC MEC states that IUD insertion up to 4 weeks postpartum is either category 1 (no restrictions) or category 2 (advantages of using the method generally outweigh theoretical or proven risks), depending on the device type and whether the insertion occurs within 10 minutes of delivery of the placenta.
 - Expulsion rates are somewhat higher when insertion occurs within 28 days of delivery.
 - Need to balance the increased risk of expulsion with the patient's ability to return to get the device later—the patient may not return if the insertion visit is scheduled later on.
- Same routine screening – no additional screening is needed.
- Note health systems issues here:
 - Immediate postpartum insertion (within 10 minutes of placental delivery) is a good option, but most hospitals aren't doing it for reasons related to logistics and billing.
 - This patient should have been counseled about contraception while in the hospital, but may not have been, so the postpartum visit is a good time to ask about this.
- Neither IUD will impact the ability to breastfeed.
- IUDs can be inserted after Cesarean delivery following the same guidelines for timing as those for vaginal birth. IUD insertion after Cesarean delivery is associated with a lower expulsion rate than insertion after vaginal delivery.
- For patients who desire an IUD after an abortion:
 - Can do immediately for procedural abortion (first and second trimester).
 - Can do 1 week after a medication abortion.

Bonnie



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Case 5: Counseling about IUD types

Bonnie is 22 years old and recently engaged. She and her partner plan to settle into their jobs and buy a house, and she wants to start trying to get pregnant in two or three years. She's heard the IUD is a great method, but there are different types and she wants to know which type you would suggest for her.

Questions:

1. Do you think this patient is a good candidate for an IUD today? Why or why not?
2. What other questions would you want to ask this patient to determine which IUD is right for her?
3. Would your recommendation be different if Bonnie didn't intend to get pregnant for 5 years or more?

Key points:

- The IUD is completely reversible and is cost-effective relative to other methods after 1-2 years. Unintended pregnancy is more expensive than any method.
- The length of time listed for each IUD is the *duration of efficacy*. Depending on the type of LNG-IUS, after 3-7 years, the device is no longer effective at preventing pregnancy, so must be removed and replaced if the patient wants to continue that method. The copper IUD is effective for 12 years, and so does not need to be removed before then, unless the patient requests it.
- Since either option would be equally good for Bonnie in terms of her family planning needs, begin counseling about the two IUD options by asking if she wants to get her period or not. If it is important to her to get her period, the copper IUD is the only option; if she would prefer to not get her period, the LNG-IUS is probably a better choice. If Bonnie has menorrhagia, the LNG-IUS might be a particularly good option for her.

Stephanie



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Case 6: Difficult insertion procedure

Stephanie is a 27-year-old woman who is here for an IUD insertion. You have completed counseling, signed the consents, and brought the instruments and device into the room.

You first start to do the bimanual exam, and Stephanie starts crying and moving around on the table. You ask her what's wrong, and she says it's just too uncomfortable.

What do you do now?

- Check in with the patient about whether she wants to continue.
 - Let her know that there are other birth control methods available, but that if she wants to have the IUD, she needs to commit to being able to stay still for the procedure.
 - Offer that she could take another method for now and return for the insertion another time (possibly with a support person to join her in the room).

Stephanie agrees to try again.

On bimanual exam, the cervix is very hard to reach. You insert the speculum, and can't visualize the cervix.

What do you do now?

- Have the patient move her bottom down the table as far as possible, tipping her pelvis forward
- If possible, elevate or alter the position of the table
- Consider changing the size of the speculum (try a smaller one)
- Might try inserting the speculum with handle up
- Double-check the patient's history: does she have a history of C-section?
- Ask another provider to try

Assume that one of the above approaches worked. You grasp the cervix with a tenaculum and begin with the uterine sound, but it doesn't go in.

What do you do now?

- Make sure you have good traction on the cervix
- Hold the cervix in traction for 5 seconds, then try again
- Make sure you're angling the sound in the direction of the uterus as assessed by bimanual exam (e.g. angled up if anteverted, down if retroverted)
- Try angling the sound in different positions (e.g. "1 o'clock," "2 o'clock," etc.)
- Consider using sterile lubricant on the sound
- If you have previous experience with uterine dilators, consider trying a 13/15 Pratt dilator
- If none of these approaches work, or if the patient becomes too uncomfortable to continue, then offer that the patient could

come back for the insertion during her menses, or another time

- Note that routine administration of misoprostol prior to insertion to ease insertion is not supported by current evidence

Xenia



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Case 7: Patient does not like irregular bleeding

Xenia is 25 years old and had a LNG-IUS placed 2 months ago. She comes in requesting IUD removal because she has been having unpredictable, irregular bleeding with cramping, and she finds that this is very inconvenient for her.

Questions:

1. What questions would you want to ask Xenia?
2. What options can you offer her?
3. How would your response be different if Xenia had a copper IUD?

Key points:

- Ask: “If the bleeding were to get better, would you want to keep your IUD?”
Although there are options you could offer her to help her keep the IUD, if she is not interested in continuing with the method, **you must remove it.**
- In the first 3 months, everyone has bleeding, with either type of IUD. With LNG-IUS, abnormal bleeding may continue, with Copper IUD, regular periods should return within 3 months. You can counsel that with any contraceptive method, most side effects occur in the first 3 months.
- What can you do at this visit? With either type of IUD:
 - Check strings to make sure the IUD is still in the right place
 - Reassure that this is normal
 - Offer ibuprofen (400-600mg)
 - Reassess pregnancy risk and consider whether pregnancy test is warranted (especially if the method was quick-started)
 - Consider checking hemoglobin, especially if bleeding is heavy
 - Offer use of pills, patch, or ring for 3 months to help regulate bleeding

Isabelle



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Case 8: Pelvic pain one year after insertion

Isabelle is a 27-year-old who has had the LNG-IUS for the past year. She comes in because she's having some pelvic pain. She says that her bleeding pattern has been irregular and spotty. Although she usually doesn't check her IUD strings, she tried to feel them recently and couldn't. When you ask about her recent sexual history, she mentions that she has been sexually active without condoms.

Questions:

1. What are your initial thoughts about this case?
2. What additional questions would you want to ask this patient?
3. What tests/diagnostics might you consider, and in what circumstances?
4. This patient has had her IUD for a year. How would your response be different if the patient had had her IUD for 6 weeks?
5. How would your response be different if she had the copper IUD?

Key points:

- Does the patient want to continue with this method? If not, remove and counsel about other methods. If yes, continue to address the problem.
- Can you visualize the strings?
 - If no, sono to see if the IUD is positioned in the uterus.
 - If IUD is not visible on sono, get a flat plate (plain x-ray) of the pelvis to make sure it is not in the pelvis.
- Consider the possibility of infection – STI testing
- IUD may be malpositioned (could be perforated, embedded, or partially expelling)
- Can offer ibuprofen – 800mg tid for several days, then prn after that. Have the patient try the ibuprofen and return for follow-up.
 - If the issue is not resolved, try sono to check positioning.
 - If the IUD is malpositioned, you can offer to remove and replace (might need to check that the patient’s insurance covers this, as some insurance plans only cover another method after the effective period of the IUD is over.)
 - There is currently not good data available regarding the contraceptive efficacy of sonographically diagnosed malpositioned IUDs.
- In the above case, the patient has had the IUD without incident for several months, suggesting that something might have changed for her, such as a new infection or changed positioning of the IUD. In a patient who had her insertion less than 3 months ago, such symptoms might reflect her body adjusting to the device. Although the symptoms would not suggest anything unusual in someone who had their IUD for less than 3 months, management would be similar:
 - Consider STI test, pregnancy test, depending on history
 - Offer ibuprofen – 800mg tid for several days, then prn after that
 - Remind her that at any point, we can remove the IUD if she no longer wants it

Ginger

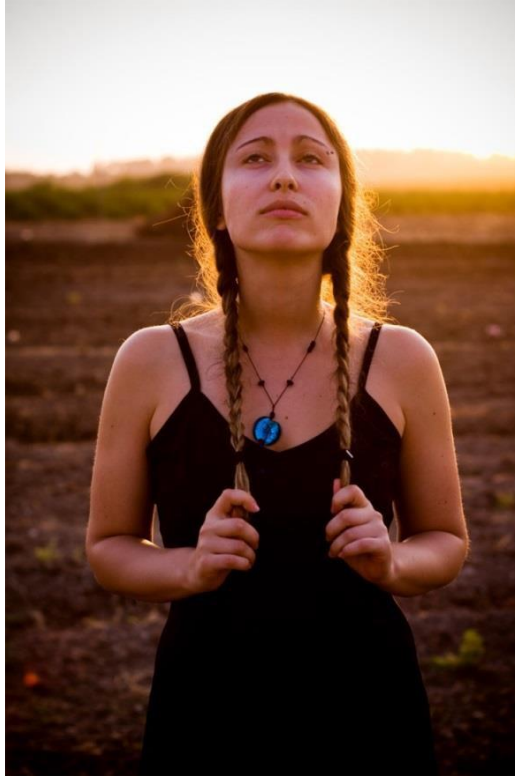


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Case 9: Removal Request – Concern about infertility

Ginger is a healthy 33-year-old woman who has had an IUD in place for the past 6 months. She presents because she would like to have the device removed. When you ask her some more questions to find out if there are specific side effects that she doesn't like, she says that there is no particular side effect, she just doesn't like the idea of having something inside of her, and she is concerned that it might make her infertile.

Questions:

1. What are your initial thoughts about this case?
2. Would you have any concerns about removing the IUD at this visit?
3. How can you communicate information about infertility risk to the patient while validating her concerns?

Key points:

- When counseling patients who come in requesting removal:

Always be ready to remove it if that is what she wants, even if you think she is not making a good choice.

- One way to phrase a response to this patient's concerns might be, "Many women have concerns about infertility with the IUD, and it's true that an earlier version of the IUD did cause this problem, but it is very different from the type of IUDs we use today. We have great evidence now that shows that IUDs don't increase your risk of infertility; infections in the pelvis do."
- In general, if the patient would like to have the device removed:
 1. Ask what her reasons for removal are, to see if there is something you can explain or counsel her about that might address her concerns, or what you can offer her to ameliorate her symptoms
 2. If her concerns are not addressed or she still wants the device removed, then remove the device
 3. If removing the device, offer counseling about other contraceptive methods
 4. If she chooses not to leave with a new method, offer pre-pregnancy counseling
 - a. Offer her folic acid and discuss smoking and alcohol cessation if appropriate
 - b. "If you do get pregnant, you can come to me for an abortion (or abortion referral) or for prenatal care."
 - c. Discuss changing any medications that are not appropriate to be taken during pregnancy
- Providers are sometimes worried about cost-effectiveness when removing IUDs early on in their effective period, but IUDs become cost-equivalent to pills in about 18 months. Even if a patient uses an IUD for only 6 months, the cost is still within the range of the contraceptive ring.
- Another issue to consider is word of mouth among patients: A patient who had her IUD removed after 2 months of use without any pushback from her provider is much more likely to tell friends about her positive experience and recommend that they try the method, as compared with someone who felt that their provider resisted removing the device when they requested removal.

Lena



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Case 10: Removal Request – Pregnancy ambivalence

Lena is a 36-year-old woman who is obese and has a history of type 2 diabetes and high blood pressure. She has had an IUD in place for 9 months, and presents because she would like it removed. She says that she just does not like the idea of having something inside of her. She is very clear with you that she just does not like the method, and that there is no particular problem that, if addressed, would cause her to want to keep the method.

Questions:

1. What are your initial thoughts about this exchange?
2. What are your concerns, and where would you go next in this encounter?

Key points:

- Just as in the previous case, if a patient is clear that she wants the device removed, you must remove it, even if you think she is not making a good choice.
- This patient has some medical conditions that would make a pregnancy high-risk for her. She may also be on teratogenic medications that should be discontinued or changed if she does not want to use a contraceptive method and is considering staying pregnant if she gets pregnant.

You agree to remove the IUD, and change the conversation to discussing her other birth control options, since she says she is not planning a pregnancy. She says she is not sure what type of birth control she wants to use. She's never liked taking pills or having the depo shot. You go through all of her options, but she does not seem interested in any of them.

Finally, you ask, "How would you feel if you were to become pregnant right now?" She tells you that she is not trying to get pregnant, but if she were to get pregnant, it would be a gift, and she would be happy.

Questions:

1. Where would you go from here?

You ask how she would feel if she were to become pregnant now, and she says that she is not trying to get pregnant, but that if she were to get pregnant, she would be happy.

- It's important to understand the concept of pregnancy ambivalence. Although many providers, as well as most reproductive health literature, think of pregnancies as either intended or unintended, many people do not experience their lives in this way. They may feel that pregnancy will happen when it happens for them, and that although they are not trying to get pregnant, that it would be welcome if it were to occur. Sometimes it can be helpful to ask a patient, "How would you feel if you were to get pregnant right now?" instead of asking whether she is planning a pregnancy.

About This Curriculum

The Case-Based Curriculum for LARC Eligibility was developed in 2014 as a project of getLARC / Grants for Education and Training in LARC. This curriculum document is one component of a larger set of resources to help family medicine residency programs improve their clinical and didactic training in LARC. Other resources include clinical protocols and a slide set, and can be found at www.getLARC.org.

About getLARC

getLARC provides funding and technical assistance to family medicine residency programs seeking to improve the LARC insertion training available to residents. The long-term goal of the getLARC project is to increase the number of family doctors providing IUDs and contraceptive implants in community health centers and federally qualified health centers nationwide. getLARC is housed within the Department of Family and Social Medicine at Montefiore Medical Center, Bronx, NY.

Additional Resources

U.S. Selected Practice Recommendations for Contraceptive Use, 2016

Available at:

https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm?s_cid=rr6504a1_w

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016.

Available at: https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf

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