IUD Placement: How to Reduce Anxiety and Pain for Patients

Brought to you by;
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Introduction
Welcome to this podcast from COR2ED independent medical education. In this episode, we will be discussing tips and tricks for addressing anxiety and pain around IUD placement. You will hear from internationally renowned experts in Obstetrics and Gynaecology; Carolyn Westhoff, Michal Yaron, and Patty Cason who will share their insights and expertise on this topic.

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Carolyn Westhoff
Hello and welcome to this podcast on tips and tricks for addressing anxiety and pain around IUD placement. I'm Carolyn Westhoff, and with me today are my colleagues, Patty Cason in California, Michal Yaron in Switzerland, and I'm in New York. All of us have a lot of experience as clinicians providing IUD placements for patients, but also a lot of experience with training people how to do this, and also working on research trials to evaluate the most comfortable way to insert IUDs.

So we will be discussing back and forth how we do this. IUDs are so very effective. They're a great contraceptive option and this podcast will help clinicians to address patients fears, anxiety, misconceptions, their questions, and concerns related to IUDs because we don't want unnecessary worries to cause patients to avoid getting an IUD, which is such a great method. Listeners will get some expert tips and recommendations. We want to address anxiety and pain pre-placement, during placement and post placement with IUDs. Now, Michal, please say hello.

Michal Yaron
Hello, everybody. I'm very pleased that we have this chance to talk today about intrauterine contraception. As you said, the most cost-effective contraception, however, used by a minority of persons with uterus. So I think it's a good opportunity to try and correct some fears.

Carolyn Westhoff
Okay. And Patty,

Patty Cason
You know, I appreciate that. And I would even go one step further and say that I'm really interested in the patient experience being improved. And I think that people sometimes really experience a lot of pain, sometimes really consider this to have been a pretty traumatic experience. And I don't think that it has to be as much as we as we have been having it. So, I'm hoping that we can actually improve the patient experience considerably.

Carolyn Westhoff
Right. And one of the reasons that patients might have a difficult experience is just if they're anxious and may be ignorant about what to expect. In our practice in very recent years, we typically do a video visit before a patient comes for an IUD placement, and that gives us a lot of opportunity to go over what to expect and elicit the patient's concerns. One of my favourite questions is just to ask a patient, what have you heard about the IUD? Because it gives it certainly gives her, you know, kind of open-ended permission to tell us perhaps what terrible things she's heard. Patty, what about you and the pre-placement conversation with your patients?

Patty Cason
I think the most important thing, and this is a generalizable principle, I think the most important thing is to do exactly what you said, which is to elicit their concerns, their questions. And I think if we listen to what they're saying and acknowledge it and then give them the information they need, I would say the next step would be to ask them a follow-up question so that you get the next concern, just to be sure that you've addressed all of the concerns. I think it's important when you're talking about informed consent to describe the main things that they need to have at the top of their mind when they're thinking about whether or not they're consenting to this procedure, the complications that are possible.

Carolyn Westhoff

Okay, Michal, what do you discuss with your patients during that pre-placement conversation?

Michal Yaron
So basically, I think it's really important to tell them the advantages and side effects and really level up expectations because sometimes the expectations are really out of reach and reality. Unfortunately, we're programmed to negative appreciations of situations. And I also spend some time with my patients to tell them that the bad reputation of IUDs are not necessarily the reality they're going to experience. So, it's really about that kind of conversation of bringing evidence-based information to people who have just had rumours or had a friend with a friend with a trauma. So that's one of the most important things for me and also to what to expect after the fitting, because there again, you have a lot of misunderstanding and misconceptions and women are really instructed to pay attention to signs of infection. Then we teach them how to feel the threads so they could also feel some kind of control over their contraception. Always give them information who to address, when to address if things go wrong.

Carolyn Westhoff
That's great. Certainly one of the last things I do as part of the pre-placement conversation is to go over the actual little tiny details of what to expect step by step. And I tell the patient that my explanation will take longer than the actual insertion will, but that they should be prepared and know what to expect. And then, of course, I will often reiterate that during the insertion now I'm doing this, now I'm doing that. So, they already know what's coming.

Michal Yaron
Now, some patients don't like that, though. Some patients do not want to be guided. And this is exactly the levelling up of expectation. Would you like to be guided? Would you like me to tell you what's my next step?

Carolyn Westhoff
I think there's variation there. Exactly. True. And one of the big things that I think we want to avoid is syncope or fainting during, during or immediately after an insertion. I don't know how many patients come in the door worried about that, but I come in the door worried about that. So, Michal, tell me how you like to deal with this. What would describe the problem?

Michal Yaron
So basically, we know that about half of the patients could have some thinkable symptoms. I mean, sometimes we don't even pay attention to them, like facial pallor, the yawning, the visual blurring, the nausea, the light-headedness or the weakness or the sudden need to go to the bathroom. So it's really important to tell the patient that if she feels very different all of a sudden, she should just say something or give us a sign, obviously, which means for us that we need to be attentive and look at the patient and not only at the IUC, or instruments.

Nonetheless, I think it was Patty who taught me the great trick what to do when they do have those pre syncope symptoms.

Carolyn Westhoff
Yes. Fill us in. Patty

Patty Cason
Yeah, it's a really common thing and it's scary. It is scary for the patient once it happens, and it and I love Carolyn's statement we know walking in the room that this is a thing we're afraid of. But I think that the most beneficial thing is to teach the patient how to handle it themselves. For years and years, I would train providers to be watchful for those present signs and symptoms and complaints of symptoms, and then to have the patient contract their muscles in their hands, their arms, their feet, their legs, isometric contractions just as hard as they can, which will avert syncope. And it'll actually stop the entire vasovagal reaction. So what I normally do is I say to the patient, when somebody has an IUD placed, many people who have this done get dizzy and sometimes they even faint. If that happens, it's probably not an indication that there's anything seriously wrong, but it can be very scary. So if you feel dizzy or nauseated or you know what? If you just feel weird in any way tense the muscles really hard in your hands and your arms and your feet and your legs, go ahead and try it now. And I have them do it. And then I will say to them, and if you do this, your symptoms should go away and it should stop you from fainting. And if you feel that way again, just tense your muscles again.

Carolyn Westhoff
That's interesting. One of the most important things I learned the hard way over the years is also not to let a patient get up too quickly after the insertions completed. I just make all my patients lie still on the table. Some of them just want to jump up and race away. Oh, I've got you know, I've got to get to work or they just want to get away from me. But I don't let them get up. And I say, we don't want to take any chance you're going to faint. And of course, I usually check somebody's pulse then, and if it's at all slow, I'm going to make them lie on the table a little longer. So that for me has been very useful. What about predicting, though, who is going to have pain or difficulties with insertion? What are the factors that might lead us to have more concern about a particular patient? Michal?

Michal Yaron
Well, we know that nulliparity is a factor and women with a history of dysmenorrhea, women who had C-sections before and did not deliver by vaginally, and also women who apprehend mostly in our actions about the fitting of the IUCS hugely tend to feel it more so. There is a lot to do on decreasing anxiety because that is not at all helpful for the procedure.

Carolyn Westhoff
Yeah, that all makes a lot of sense. I agree. One other aspect of C-sections is the surgical repair can change the direction of the cervical canal and so that can also make insertion more challenging. And so, we really need to we need to know about all of these factors in our patients before we start the procedure. Anything to add to that? Patty?

Patty Cason
Yeah, a few things. Uterine length in some studies has been associated. A person who has a history of dysmenorrhea may be associated with increased pain during placement too. Interestingly, menstruation specifically for nulliparous. So, I think that's a that's a pretty interesting tidbit. And if there's difficulty with the sounding, a lot of times the placement of the device itself is going to be painful as well. The size of the inserter may or may not have any impact on this. There are a bunch of nonphysical factors, things like a history of sexual trauma, for example. And so many of our patients have a history of sexual trauma. I was going to say, when we're describing the procedure as well, which was the conversation that you and Michal were having, I think it's really important to let the patient guide how much you tell them. And I generally will say, would you like me to describe the entire procedure to you? Would you like me to tell you, or would you prefer I tell you when as we're going, what's going on? Or would you prefer I just tell you what to expect the moment before it's going to happen? Or do you want to know nothing? And people respond with a whole wide variety of answers. So, I generally think from this trauma informed perspective, for somebody with a history of trauma really can be applied universally to everybody. I think it's a really good idea to as much as possible, keep them in control. That's how they are going to be most able to experience this in a way that's not going to be retraumatizing for them and for the general person that doesn't have a very strong history of trauma. It's also really helpful to be able to be in the driver's seat.

Michal Yaron
Maybe just attention to one more thing that I think we overlook is to ask the patient how she felt in the last gynaecological exam and if that was a painful exam, we should be already a little bit sensitized to the fact that it could be a bit more of a struggle for her to go through the fitting. So, I think previous gynaecological exam history is also contributive.

Patty Cason
And very much the expectation of pain.

Carolyn Westhoff
Yes, I agree with everything you've just said in my practice. We get written, informed consent for all procedures, including an IUD placement. So, when I'm obtaining that, when I'm describing all the steps of the procedure, that will include then risks and benefits, and then that will be the opportunity for the patient to sign a written informed consent.
Is that similar in your practices?

Michal Yaron
Yes, absolutely. We do exactly the same thing. And as you know, in Switzerland, there are many origins of people. So, we have that kind of informed consent already translated into many languages now.

Carolyn Westhoff

Okay. And now I'd like to switch gears a little bit and think about the insertion. And I want to ask you what you offer in terms of analgesia and anaesthesia during the IUD insertion. I think they're probably differences between practice in the U.S., in Europe. So Patty?

Patty Cason
Well, I'm so happy that now we finally have data saying that a cervical block makes it less painful. You know, for years that was the question. Is the discomfort of the cervical block worth the pain relief that it affords? So, I really encourage everybody to talk to the patient. If you have if you have the ability to do a block and it's a very simple thing to learn how to do, to really offer that to patients pretty liberally, I would say pretty much everybody, if you have that ability to do that, to offer it, it doesn't mean everybody's going to want it, but at least to offer it. We generally, I've always put given some of the NSAIDs prior to placement, I like them to have the NSAIDS a longer period of time before rather than a shorter period of time. And the data just aren't supporting that. It's going to help with the placement, but it can help with post placement cramping.

Carolyn Westhoff
Oh, okay. Michal, other thoughts on that?

Michal Yaron
Well, I don't think the literature is sound about the analgesia that is the best for intrauterine contraception. I mean, there are some offers, but, you know, they're based on studies that were really single trials and not huge number of patients. So again, I think each one of us should feel comfortable with whatever we want to offer to the patients. But I think one of the things that works probably the best is verbal analgesia, kind of engage the patient in small talk, talk about her vacation, make her wander off the procedure itself. And I think that that has some calming effect to say even more. I think we need to be calm. If we're calm and we're kind of comfortable with a procedure, I think it could transcend to the patients and give them some sort of reassurance that has been my experience.

Michal Yaron
Here in Geneva University hospitals, we use the nitrous oxide analgesic, although in studies it was not shown to be improving the sensation of pain. But I did see the effect of lowering the anxiety. So, in some patients, even though I'm not convinced it's going to lower their pain, I know it's going to make them a bit calmer and a little bit maybe less prone to pain sensation.

Patty Cason
I would love to have nitrous oxide available in the sites that I have worked in or would work in because it's pretty rare in the United States outside of either dental or OB context. I wanted to add that when we're talking with somebody in order to help distract them, I think it helps if the patient is doing the talking. It's about their life. And I think that allowing them to lead the conversation but keeping them going with the conversation, it's always, I find

best to ask the patient what works for them. What have you done in the past when you've done something that was potentially going to be uncomfortable or painful? What have you done in the past that helps you and then help support them in doing that in the future, giving them clear license to use their cell phone. Because, you know, one person I know tells patients don't check your email for X period of time or don't check your social media for X period of time before you come in so that you have a lot to look at while you're having an IUD placed.

Carolyn Westhoff
That's great.

Patty Cason
And you know, we always could do a heating pad that's lavender essential oils. I mean, there's a lot of tips.

Carolyn Westhoff
Yeah, well, lavender seems to be a great thing for reducing anxiety. Okay, well, it's great to hear about everybody's experience. I think a key take home that I heard from both of you is listen to the patient. This is not all about the clinician doing the talking. It's about clinicians learning to do listening and to elicit information. So, moving on now to the placement process itself, Patty, can you share some practical tips to set up for a successful procedure?

Patty Cason
Yes, yeah, definitely. One of the things is it's a tenaculum is uncomfortable for most people or painful or pinching for most people, like describing it, I don't think is particularly helpful to people to talk about pinching or holding on to or grasping your cervix I think is a little bit so I don't actually describe it. Placing it extremely slowly. If you're not going to put a block or at least put some lidocaine on the side of the tenaculum placement, closing the teeth together extremely slowly and making sure that the instrument is sharp is really, really helpful. Making sure that this doesn't make that sound when it's closing the ratchet and instead just really placing the ratchet to close itself with one or two clicks of the ratchet. But silently, because it doesn't feel great if you're the person getting the tenaculum placed on you to hear it go … on your cervix. Make sure that there is enough light so that you're not putzing around because every second is something somebody feels and make sure all the instruments you could potentially need, including OS finders and or a small dilator, definitely a ring forceps in case you need to pull the device out, having all those instruments in place beforehand so you're not during the procedure saying, Oh, let me just get my medical assistant to step out and get an instrument that I don't have.

Another thing that's really important is to not take too large of a bite because it's more painful that it has to be in another. Another aspect of that is not to take too shallow of a bite because it will tear through it, which isn't going to damage the cervix, but it can definitely freak out the clinician and then it's not comfortable for the patient because then you have to go ahead and place it again once it's once it's come off. And a technique some people do is to have the patient cough and put the tenaculum back in them. And quite

quickly, if you do that, make sure you hold on to the speculum, so it doesn't get popped out when they cough and have them practice the cough first. Otherwise, you're going to probably hear them go, which is probably not going to accomplish what you want to accomplish, but to have the tenaculum right against the cervix and then have them cough so that you're already in position ready to go when they when they cough.

Michal Yaron
Using smaller speculums is actually do less kinking of the cervix with the uterine cavity and help in the procedure to be less forceful.

Patty Cason
That's such a really important point. And plus, if you use a speculum that's too long, it's actually going to make it difficult to be able to even straighten out the canal or even get through the cervix. It's very counterintuitive because people think, well, I'm having difficulty seeing or I'm having difficulty getting the sound through, so I should use a large speculum. But it's quite the reverse, too. So yeah, I'm so happy you brought that up that you want to use the smallest speculum that you can use. One of the things that can be quite unpleasant for a patient is a perforation. And it's the thing that we are almost afraid of. One technique that you can try that's very helpful is to hold a sound and also the inserter or with a very gentle touch, just using fingers or wrist action, not elbow action. So you really don't create a lot of force with the sound, which is the main thing that will be perforating. And also, once you get through the internal OS, pause for a beat and then intentionally proceed slowly to the fundus, going slowly with every step of the procedure is going to be more comfortable for the patient. It's not going to cost a lot of time, you know, like seconds or like a minute to slow down a little bit. Taking that little pause after going through the internal OS allows you to have the intention to go up to the fundus without momentum. It's that momentum of trying to get through the OS and then you succeed, and you've got some momentum and keep on going. So that's what we want to avoid.

Checking strings is a wonderful thing. If the person wants to do it and you can do it prior to the placement by giving them a device, a little demo device of an IUD and having you or they place it in their palm, hopefully they've already felt it and they can see that it's small and flexible and it just doesn't seem so intimidating. But putting the IUD in the palm, closing the palm around it and having the string come out, if you make the fist with the palm allows the person to see what they'd be feeling for with the strings as well as you can have the little tip of the bottom of the IUD come out, you know, out of the bottom of the palm and you can tell them this is what it would feel like if it was being pushed out.

Carolyn Westhoff
Right. I like that a lot. Now, there are some alternatives coming up, including a suction cervical stabilizer. So, Michal, can you describe that for us?

Michal Yaron
Yes. So the suction, cervical stabilizer is a traumatic single use device and it uses suction force, which is created by pulling a sliding tube and affixing the semi-circular suction pad on

the cervix so the device could be reloaded a couple of times. So there is no problem with the suction. There is a vacuum loss. And basically we use it like if you want to imagine, it's like a little vacuum delivery where we put the vacuum on the head of the baby, although it is a lot smaller. So basically with that kind of device, we have shown in our study that we have less pain on the different steps of IUDs fitting.

Carolyn Westhoff
How large was this randomized trial that you ran?

Michal Yaron
So it was on 124 patients who were randomized. 100 responded to the inclusion criteria, and among them we had 55% nulliparous and the groups are very homogeneous. There was no statistical difference between them. So 100 patients.

Carolyn Westhoff
What were the results?

Michal Yaron
So let's talk first about what is a clinically significant difference in pain. Well, that was defined between 15 to 20 millimetres on a 100-millimetre visual analogue scale, the VAS. So the randomised controlled trial compared the single toothed tenaculum with the suction cervical stabiliser and in this study, in the whole cohort, using the suctioned device, pain was reduced from a range of 10 to 19 millimetres on the VAS scale, basically to more than 50% less pain during cervix grasping and traction and 30% less pain during the most painful step, which is the IUC insertion into the cavity.
The greatest difference between the study arms were observed in nulliparous, where they experience a decreased pain of 23 to 32 and a half millimetres on the VAS and this was basically more than 70% reduction in pain in cervical grasping and traction and 44% less pain in IUC insertion. We also had 78% less bleeding with the suction cervical stabilizer compared to a single tooth tenaculum.

Carolyn Westhoff
Yeah, that's great. We've all been we've all been grasping the cervix pretty much the same way forever. So I'm glad to hear there's some innovation in this area. So, Patty, what do you think about this?

Patty Cason
I think it's really exciting. I am really looking forward to seeing how things evolve once it's been out and been used. I know that in the study there were some instances where it came off from the cervix and I'm anticipating that they're going to go back and rejigger it a little bit.

Michal Yaron
So here is the scoop. Our study kind of it helped them improve the instrument. And right now, the suction is a bit stronger and therefore there is less falling off. And we were using

actually an instrument that was manufactured on a 3D printer and there were really prototypes. And today the new instrument is gorgeous, easy to use, and I already tried it, the new models and they're a lot better. So, I think that problem was already addressed to some extent. But you will always find a cervix that is either too large or too small that they won't do the job. But one of the things that I learned with this study, and that was for my biggest amazement, to be honest, was that finally to align the cervix with the uterine cavity, you need very little pulling, something that we don't have the same let's say we're not as wary when we use a tenaculum. I think we're more comfortable pulling on it a little bit more. But here, because you are afraid it will fall off, we could pull much less and have still good procedures. That that was something interesting for me that I learned from this study actually.

Carolyn Westhoff
That's great to hear. So just before we move on to post placement, I think that the key here first we started our training. You got to listen to the patient. That's true here during insertion, have everything ready, offer analgesics and anaesthetics and use the smallest speculum you can. I completely endorse that. Now, what about after placement, Patty? Anything you want to suggest about after placement?

Patty Cason
I think anticipatory guidance is very important and letting people know that it's likely that they'll have cramping for a while afterwards. It's not unusual and some amount of spotting is completely normal. I think also if the person's going to have a non-hormonal IUD, then explaining to them about use of NSAIDs pre-emptively, at least for the first three cycles to reduce the amount of bleeding that they'll have because the amount of bleeding that someone has with a non-hormonal IUD, as everybody knows, is on average going to increase. And if you use NSAIDs pre-emptively about 24, 48 hours before the menses begins, it will really reduce the amount of prostaglandin in the uterus, which is what's responsible for the increase in bleeding. So, it's a really important thing to, I think, say to somebody before they have had the experience of having the heavy bleeding, but to tell them to expect it and that NSAIDs can really mitigate against some of that.

Carolyn Westhoff
Oh, okay. That's great. And Michal?

Michal Yaron
The changes in bleeding patterns, this is something I, I think is worth explaining because a lot of women, once they see bleeding that are off their regular cycles, tend to worry that maybe the IUC does not work or there is something wrong with them.
So, it's really important to talk about these changes.

Michal Yaron
The last thing that we also ask patient is we teach them how to feel the threads and within the four, six weeks after the fitting. So they should learn to do it at regular intervals so they have some kind of confidence the IUC is still in place. And we teach them about symptoms

of pelvic infection, like the changes in vaginal discharge, pelvic pain and post-coital bleeding. All this in order for them to know when to address concerns to a health care provider.

Carolyn Westhoff
Yeah, those are great. Yes. One thing about the discharge is that I've observed over the years, and I've never seen a study on this that many women might have an increased mucus discharge in the first month or two. They're just a little bit wetter and they might misinterpret that as infection if they are not given some information ahead of time that this could occur. Now, just before we close, one thing that I think is fairly controversial, in fact, is what should we do with ultrasound, either before, during or after placement? I'd like to hear your thoughts on that.

Patty Cason
Well, I think it really depends on the site. It's really pretty much determined by what's available. So if I if I have an ultrasound machine right by my side and I've got a patient that I'm placing an IUD with, I would consider using it if there was any kind of issue that happened, if I was concerned about the positioning, if there was an unexpected amount of pain, if I have any concern with the way that it felt while I was placing, I would absolutely look with an ultrasound. I would not look stand as a standard. If you do do it, it can be something that the patient likes because it gives them confirmation that everything went well, definitely would give me confirmation too. But I think that it's I would hesitate to make it standard of care because there really is not easy availability in all sites to use an ultrasound. And it really hasn't been shown to be something that's important for outcomes to be improved or it hasn't been shown that there's any real difference.

Carolyn Westhoff
There certainly are not high-quality studies showing a benefit in terms of pain. I do typically have ultrasonography available and the two times I want to use it with insertion is going to be if the patient, let's say, has had multiple C-sections or if she's morbidly obese and that it just might be a more anatomically challenging insertion, and there I really like the benefit of the additional information from imaging the cavity and I can see whether I'm in the right place also, sometimes with a learner, it's a way for me to keep track of whether the learner is doing a correct placement and I can't always just succeed in that by completely remote control so sometimes the abdominal sonograms useful there, although I don't use it routinely.
So, Michal, how is this used in Switzerland?

Michal Yaron
My approach to it is to use it, but we're putting more IUDs in nulliparous where we don't know really what kind of uteruses they have. Unfortunately, we had two cases where an IUD was placed in one uterine horn and not in another, or so I do prefer that they would do the ultrasound before and after to ensure that it's into intra cavity. I do agree that it's probably a question of availability, but for me it could be part of the procedure. Now, you said something very interesting, Patty. It's true. Studies shows that basically the positioning of the IUD is not predictive, an ultrasound is not predictive of imminent expulsion or

necessarily expulsion. So, you know, that use of it is probably not as important. By the way, the faculty from England on sexual and reproductive health care and the French consortium, they do not push for an ultrasound during or after.

Carolyn Westhoff
I think we all agree that you have to be flexible and that there are some situations where, if available, it can be helpful. It's time for us to close. I would like actually for each of you to give us one or two key takeaways from today's conversation.

Michal Yaron
IUCs are safe, they're long lasting, and they're reversible contraception, and I think they should be offered to all person with the uterus and including young nulliparous patients. I think thanks to the suction cervical stabilizer, we have maybe a promise to decrease the main obstacle for insertion nulliparous, which is fear of pain for the providers as well as the patients. And I just hope it will lift this big barrier in the future and we'll see more uptake of IUCs.

Carolyn Westhoff
That's great. And Patty?

Patty Cason
I would say that keeping a perspective of what the experience is like for the patient from the very first moment when they make their appointment all the way through their follow up time is critically important. You know, we see patients all day long and we can sometimes sort of get into our own routine and not really be thinking about what that person's experience is. So I think it's important to always think about what's that experience like for them to feel this cold speculum and what is that experience like for them when somebody just walked in the room just to think about that and the other the other part of that is to in every step of the procedure, both before, during and after, is to try to do anything we can to keep the patient in control, to be the patient who's saying yes to consent, to continue the procedure, that the patient knows that if it's really, really not something they can handle, that you'll stop at any time. So keeping that patient completely in control.

Michal Yaron
It's almost like you were saying, stay humble with the fitting. You know, sometimes we're like we know we can do it. And with IUD fitting, you got to stay humble until the last breath of the procedure and actually what you were describing felt that you were actually saying that.

Carolyn Westhoff
Those are great points, and while we discussed a lot of different medical issues, you think the most important thing is that we show our patient that we really care about her experience and that we're really committed to reducing the pain, and that can be very reassuring for patients that we show them we care about this. The goal of this podcast is really about how to address pain and anxiety during IUD placement, but I hope you've all

heard a lot of other tips and tricks to improve the entire experience. I want to thank everybody for listening, goodbye.

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