CLINICAL PROBLEMS & ANSWERS FOR MASTERCLASSES 2015

MIRENA QUESTIONS

1. THREAD ISSUES

http://www.fsrh.org/pdfs/CEUGuidanceIntrauterineContraceptionNov07.pdf

Missing strings was a common problem mentioned by colleagues.

PLEASE CUT YOUR IUD STRINGS **LONG** AS A RULE SO THIS STOPS HAPPENING

There is a good lost string protocol on the ICGP site.

Even if **you didn't insert the device** you are responsible for managing the woman at this point (e.g. You are doing a CSP smear on a lady who says she has a coil but you don't see any strings)… you need to:

Reassure the woman that the commonest cause of missing strings is them being drawn up into the cervical canal…. BUT Warn her that it is ***possible*** the device itself is not in situ… to be safe she should:

Have a **Pregnancy Test**. …If appropriate offer POST COITAL CONTRACEPTION

If the **PT is negative** you may offer to try and gently tease the strings down from the canal with an Emmet Retriever/forceps/smear brush. Warn her that this may dislodge the device…

If unsuccessful consider trying again in a day or two… it is not uncommon for the strings to reappear a few days after intra cervical manipulation! Cytotec may help also

If she wants the device OUT there and then you can skip the Emmet and use either a Uterine Hook or the Gräfenberg Hook or a Hartmann's alligator forceps…Cytotec helps here too ...if you are unsuccessful she needs IMAGING to confirm the position of the device BEFORE YOU EXPLORE ANY FURTHER!

TV USS is the best… a plain film of abdomen/pelvis can help exclude extra uterine devices if there's limited access to US. If she is happy to continue using the device and you can't/ won't explore the canal with the Emmet retriever…
A. Start on alternative CONTRACEPTION until the device is located.
B. IMAGING to confirm location..Once you can confirm it is fundally situated she can then continue using the device… it would be ideal to draw the strings down but it's not absolutely necessary… in that event she might like to get yearly confirmation via USS.

If the pregnancy test is POSITIVE….

She may have an increased **risk of ECTOPIC** and so should be referred urgently for confirmation USS. The device should be removed **by the OBS/ Gynae** as the lady has an increased risk of late trimester miscarriage if left in… the risk of inducing an immediate miscarriage is significant when removing the IUS especially if it is located above the implanted pregnancy. They may choose to leave the device in situ of the pregnancy has implanted safely above the IUD.

If the device has migrated extra uterine it MUST be removed… REFER. And then follow up:

It is usually impossible to detect an IUD that is located outside the uterus with USS!

Get a PFA and pelvis

I have heard of a case where there was a lost Mirena & a positive PT. The patient was referred to Obs Gynae and the GP felt they had things in hand. The baby was born …uncomplicated.

The patient was content after her initial surprise & disappointment.... but many months later she had symptoms which prompted further investigation, turned out the Gynaes never did the PFA to out rule extra uterine IUS.. It was finally removed from the omentum almost 2 years after the initial complaint of missing strings! Case pending.

************A colleague says there is a 12 month wait for gynae removal of IUS in their area..what to do with women who can't afford private Gynae. I suggest referral to a colleague first; there should be discussion say within CME groups etc as to who would be willing to take inter- surgery referrals for tricky insertions removals etc.... or NMH Clinic ************

The flip side to missing strings is strings that annoy the patient or her partner.

If the strings are cut too short this may happen so err on the side of too long rather than too short! If possible gently “milk” the strings behind the posterior of the cervix toward the post fornix. You can shorten the strings but anything less than 1 inch is likely to result in missing strings and require outside help at time of removal... her choice ultimately.

2. EXCLUSION CRITERIA FOR IUS QUESTIONS

Women with confirmed PE's or DVT +/- on Warfarin; cat 3 for both/ Women with known thrombophilias (& menorrhagia) Cat 2 for iucd but cat 1 for ius/; Nulliparous women cat 1 for both/, Adolescents cat 2 for both/, Women who have had multiple C Sections, Women who are severely retroverted, Breast feeding women cat 1 for both, Severely obese women cat 1 for both, Bacterial endocarditis? Antibiotic cover ("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). When prophylaxis against bacterial endocarditis is required, clinicians should refer to the BNF for the most up-to-date regimen and ensure the intrauterine contraceptive procedure takes place in an appropriate setting (Good Practice Point").

Asymptomatic ALO & MRSA infections cat 1 for both:
(“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 considered and it may be appropriate to remove the intrauterine method”)
Same guidance document as above:
http://www.fsrh.org/pdfs/CEUGuidanceIntrauterineContraceptionNov07.pdf

Cat 4 contraindications for IUD include: Pregnancy, trophoblastic disease, CURRENT PID and some reproductive Cancers (cervix, uterine for both... breast for just IUS)

3. INSERTION PROBLEMS

Vaso vagal attack (Pulse rate and blood pressure should be assessed and documented when appropriate and depending on the clinical situation when inserting contraception (Good Practice Point) Vocal local, enquire about fainting during menses)/ nausea after insertion, Abd pain & dyspareunia post insertion (may imply short canal or malposition; try NSAID if mild, investigate if more severe) Tight cervix especially in Nullips & in older women & women on depo (Cervical Stenosis may be eased with Cytotec or Arthrotec .... low E2 (such as perimenopausal women) will make insertion more challenging.. try E2 priming & avoid insertion during menstruation), Spasm after IUS removal preventing re insertion (common enough; warn patient so as to lower expectations, try Cytotec),

Failed insertion ? fibroid, Expulsion soon after fitting & in women with severe menorrhagia (THIS IS KNOWN TO BE MORE COMMON IN MENORRHAGIC WOMEN- PERHAPS CONTINUE BRIDGING CONTRACEPTION), Ovary in POD (NO IDEA), Short uterine canal (either abandon current attempt or have short frame alternatives on hand), Post C Section/ Post Multiple C-section (no specific concerns unless the surgeries were complicated ??), , Partial expulsions (more than 2 mm from fundus is considered displaced and device should be removed and a new one inserted.. you may not push it up !), Constipation after insertion (curious.. perhaps psychogenic- afraid to strain?)

Vaginal numbness after IUS insertion .. No idea /unlikely to be a consequence of the procedure

This is from a NY solicitor’s website.. be sure WE do what they suggest excludes the women from the class action suit:

Mirena IUD Lawsuit Checklist

The Mirena IUD causes many symptoms and complications however, in order to file a Mirena IUD lawsuit your Mirena IUD lawyer will be looking for the following:

1. Mirena IUD must be the product implanted
2. You must have gone to your 4-6 week follow up appointment and your doctor has confirmed that your Mirena IUD was properly implanted.
3. The Mirena IUD has perforated your uterus or other organ. The Mirena must have moved out of position, gravitated and has become embedded in your uterus or an organ and/or there is a perforation injury.
4. This usually means the Mirena needs to be or will be surgically removed.

A lot of Mirena women either don’t go to follow up appointment or by the time they go to follow up the Mirena has already moved. If that happens this becomes a med mal issue and not a products issue. The statute of limitations starts to run when you knew Mirena perforated an organ.

Of course, consult with your doctor if you are experiencing any of the symptoms listed above to see if the Mirena has moved and caused a perforation. Consult with one of our Mirena IUD lawyers to be sure.

4. SIDE EFFECTS, COMPLICATIONS POST IUD PLACEMENT

Identifying post menopause (random FSH; if > 30 repeat in 6 weeks, if still>30; then offer removal at her convenience but advise barrier for 12 months more just in case). See http://www.fsrh.org/pdfs/ContraceptionOver40July10.pd which states “If amenorrhoeic either check FSH levels and stop method after 1 year if serum FSH is ≥30 IU/L on two occasions 6 weeks apart “

Irregular Bleeding (see same resource) Weight Gain (rare but known complication- unlikely to be improved with ANY other hormonal method- but also may be coincidence) Copper Coil & Alopecia (no studies, some anecdotal mention on line- perhaps anaemic hair loss secondary to menorrhagia?? Cu allergy?? When it doubt/take it out)

Unable to remove a device inserted after endometrial ablation (refer for hysteroscopic removal) GMS/Psych patients requesting immediate removal (that is their right… you need to ensure they have adequate pre insertion counselling and a management plan + Rx on the day of insertion) Amenorrhoeic & unhappy about it/ cultural?   (see above – counselling) LLETZ procedure (many colposcopists are skilled at working around the strings..but some are woeful... alt ask them to push the strings deep into the canal.. you can fish them out later) FAILURES (they happen ! 50& result from expulsion of device. Did you warn her of failure, do a 6 week review, warn her to check for strings or to contact you/return asap if strings impalpable or bleed pattern changes abruptly)… many pregnancies seem to occur where no post placement check was done. If she is pregnant MAKE SURE THE DEVICE HAS LEFT THE BODY)

IMPLANON QUESTIONS

See http://www.fsrh.org/pdfs/CEUGuidanceProgestogenOnlyImplantsApril08.pdf

Who to avoid: UKMEC 3 : Current VTE on anticoagulants, Current/arising ischaemic heart disease (continuation), Stroke (continuation), Migraine headaches with aura at any age (continuation), Unexplained vaginal bleeding suspicious for serious condition, Gestational trophoblastic neoplasia when hCG is abnormal, Breast disease past history of breast cancer and no evidence of recurrence for 5 years , Viral hepatitis active disease, Cirrhosis severe decompensated disease, Liver tumours benign and malignant, Drugs which induce liver enzymes [e.g. rifampicin, rifabutin, St John’s Wort, griseofulvin, and certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)

UKMEC 4 :Current breast cancer

1. Broken Devices Complications with removal

The incidence of complications at implant removal is low (1.3%).52 Complications include broken implant, migration of implant, and difficulty locating the implant. If the implant cannot be palpated, methods such as Xray (for the NXTs), ultrasound or magnetic resonance imaging can be used.

2. Impalpable devices at removal – exploratory surgery! See above

3. Multiple devices inserted unwittingly

4. Disruptive Bleeding (see FSRH guidelines)

5. Difficulty with superficial placement during out & in (use different track or other arm)

6. Scarring making removal difficult (no need to go in from distal end.. try proximal or mid shaft)

7. Swelling in arm post insertion may be infection, may be allergy, may be haematoma)

END