Addressing and Preventing Pain and Anxiety With IUD Placement

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September 17, 2024

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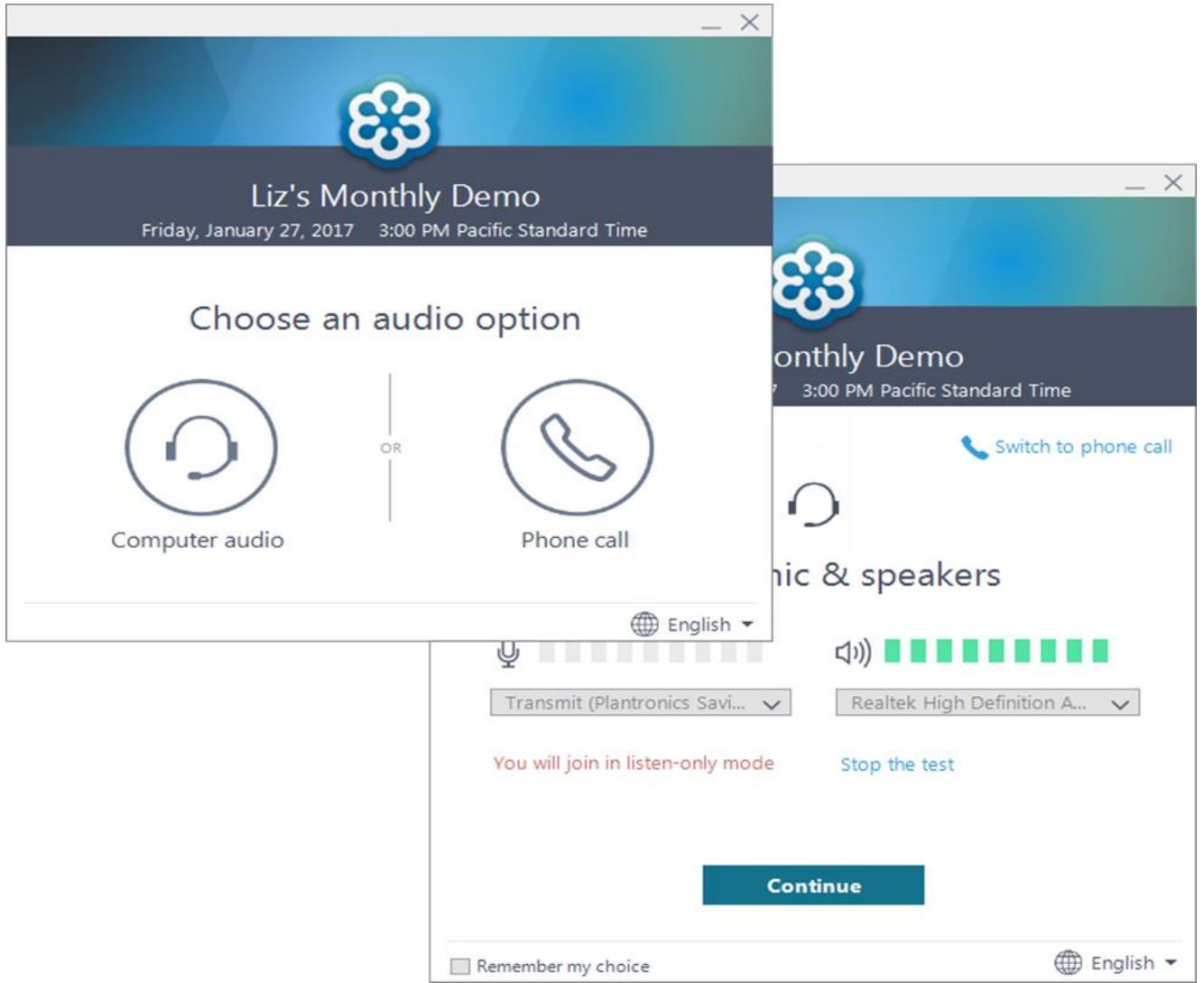

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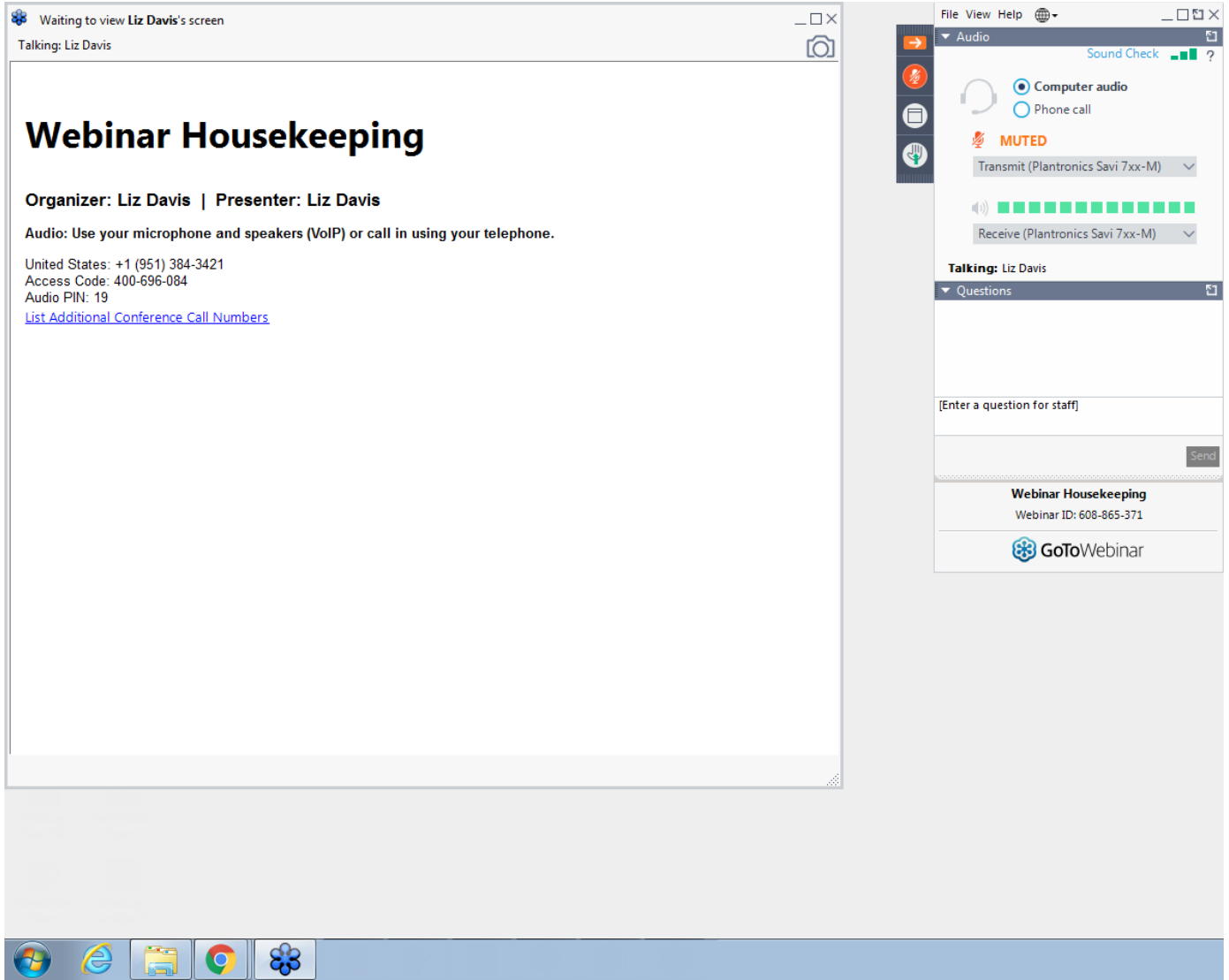

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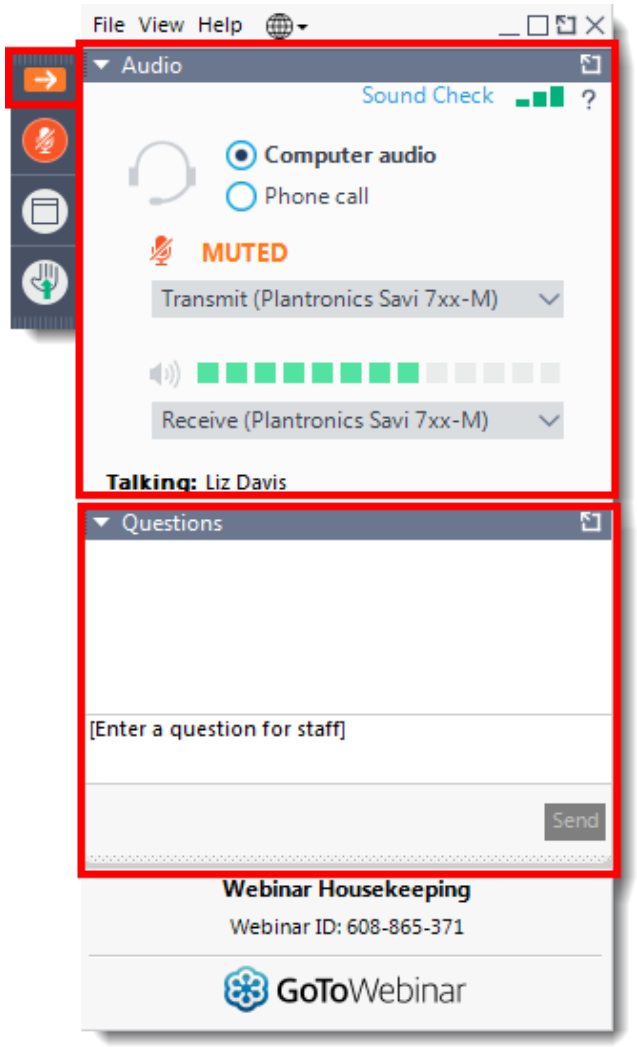

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- The following presenters has/have disclosed the following relationship with an ineligible entity.
- Joely Pritzker – Trainer: Organon
- Patty Cason – Trainer: Organon; Consultant/Trainer: Sebela Women's Health

Presenters

Joely Pritzker, MS, FNP-C

Nurse Practitioner at Vista Community Clinic in California

National Trainer for Envision SRH and the PATH Framework Sexual and Reproductive Health Trainer and Consultant

Contributing author for the 22nd Edition of *Contraceptive Technology*

Presenters

Patty Cason, MS, FNP-BC

Assistant Clinical Professor and guest lecturer at the UCLA School of Nursing

Serves on the ASCCP Board of Directors, the National Medical Committee for Planned Parenthood Federation of America, and the National Clinical Training Center for Family Planning Advisory Board

Developed the PATH framework and the ASA Cycle for person-centered conversations and counseling

Disclosures

- Pritzker
  - Organon: Trainer
- Cason
  - Organon: Trainer
  - Sebela Women's Health: Consultant/Trainer

Objectives

- List 3 non-pharmacologic interventions designed to prevent pain with IUD placement
- Demonstrate anticipatory guidance for vasovagal prevention
- Describe the evidence for providing a cervical block to reduce pain with IUD placement

Elicit and address patient concerns
Use anticipatory guidance
Be prepared
The patient is the expert
Blocks work
Be gentle … *in all ways*

GO SLOW

Factors Associated With Increased Potential for Painful IUD Placement

Physical Factors	Psychological and Sociocultural Factors
Low parity, nulliparous	Number of years in education (>7)
> 13 months between last birth and placement	Presence of mood disorders
Not breastfeeding at time of placement	History of sexual trauma
Multiple cesarean deliveries	Previous negative reaction to vaginal examination
History of Dysmenorrhea	Previous placement reported as painful
Shorter uterine length	Awareness of the potential for pain from another
Difficulty or pain when using sound	Anticipation or expectation of pain
Larger insertion tube	Age-adolescence

Adapted from: Gemzell-Danielsson 2019
Rahman, M 2024; Schneyer 2022; Hunter 2020,

- Timing of placement

  -- during menses vs. not menstruating --

is **not** associated with increased pain during IUD Placement

van der Heijden 2017

PRIOR TO IUD Placement

- Apply principles of trauma-informed care
- Have the room fully set up
- Anticipatory guidance re: vasovagal prevention
- What to expect and how much information do they want during placement?
- NSAIDs
- Oral sedation

A Pre-placement Conversation

- Puts the **patient in control**
- It is a time to:
  - Ask about their concerns so you can address them
  - Ask how much detailed information they want about the procedure and when they want it
  - Explain potential complications in patient-centered language
    - Use words and phrases that are less scary or aggressive sounding
    - Pair complications with their "solution"
  - Is a time to establish that you will stop at any point the patient wishes

Avoid Overly Medical or Alarming Language

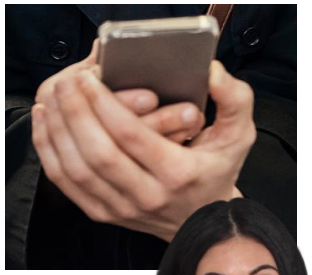
Insertion	→	Placement
Grabbing or Pinching or Stabilizing	→	Holding
Expulsion or Body Rejecting IUD	→	Uterus pushed it out and we can place another

Discussing Pain Management Options with Clients

- If a client has already shared concerns about pain, use that as a starting point for this conversation.
- "To help with pain during the IUD placement, we can put some numbing medicine in your cervix. Many people say that this feels a bit uncomfortable and like a strong pinch. But it's quick, and we would expect you to have less pain with the IUD placement once we've placed the numbing medicine. Is that something you're interested in?"
- If a client is interested, follow up with "What questions do you have about the numbing medicine?"

What Works for the Patient? (ASK)

- Breathing techniques
- Heating pad
- Lavender essential oils
- Cell phone
- Mindfulness, meditation, guided imagery



Prepare the Room and Instruments

- Make sure **all instruments and materials** are readily available including os finders or the equivalent
- Cover instruments and povidone iodine
- Make sure there is sufficient light
- Adjust position so you are comfortable

Is the Patient Comfortable?

- Ask to remove only essential clothing
- Temperature of room
- Heating pad
- Warm speculum

Medication

2024 Selected Practice Recommendation (US SPR) Updates for Provision of Medication for IUD Placements

- Misoprostol is not recommended for routine use for IUD placement. Misoprostol might be useful in selected circumstances (e.g., in patients with a recent failed placement).
- Lidocaine (paracervical block or topical) for IUD placement might be useful for reducing patient pain.*

(Curtis 2024)

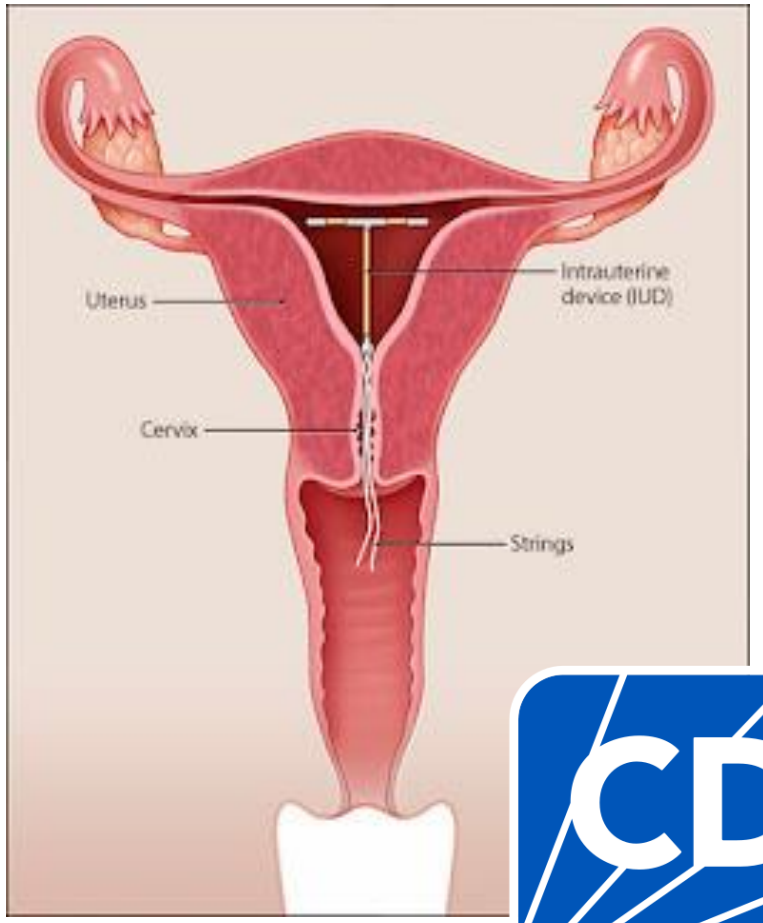
Medication

- Naproxen, Tramadol, ketorolac give some pain reduction
  - Helps with post-placement cramping
- Sedation
  - Oral : Benzodiazepine + acetaminophen + opioid
  - Light/moderate IV sedation
  - Deeper anesthesia for patients who need it
    - Know resources for clients and no need to require them to have a “failed” placement first
- Nitrous oxide

Fowler 2021; Singh 2016; Schneider 2016; Miles 2019; Lopez 2015

NSAIDS to Decrease Bleeding and Cramping With Menses

- NSAIDs prophylactically **WITH FOOD**
  - Use liberally post-placement for cramping and pain
  - Pre-emptive use for 1st 3 cycles (Copper IUD)
    - Start before the onset of menses for anti-prostaglandin effect
    - OTC Naproxen sodium 220mg x2 BID (max 1100mg/day) (If Rx-Anaprox DS)
    - Ibuprofen 600-800mg TID (max 2400mg/day)



Godfrey 2013; Grimes 2006

Misoprostol not Effective

- Not shown to reduce pain or facilitate ease of placement
- Increases uncomfortable side effects and abdominal cramps
- Pain scores shown to increase with both sublingual and buccal misoprostol
- IUD placement failure may be reduced with premedication among:
  - Those returning for a second attempt after a failed placement
  - Those with previous caesarean section

Tassi 2020;Bahamondes 2015

Vasovagal Reflex (Reaction) & Syncope

Pre-syncopal Signs & Symptoms

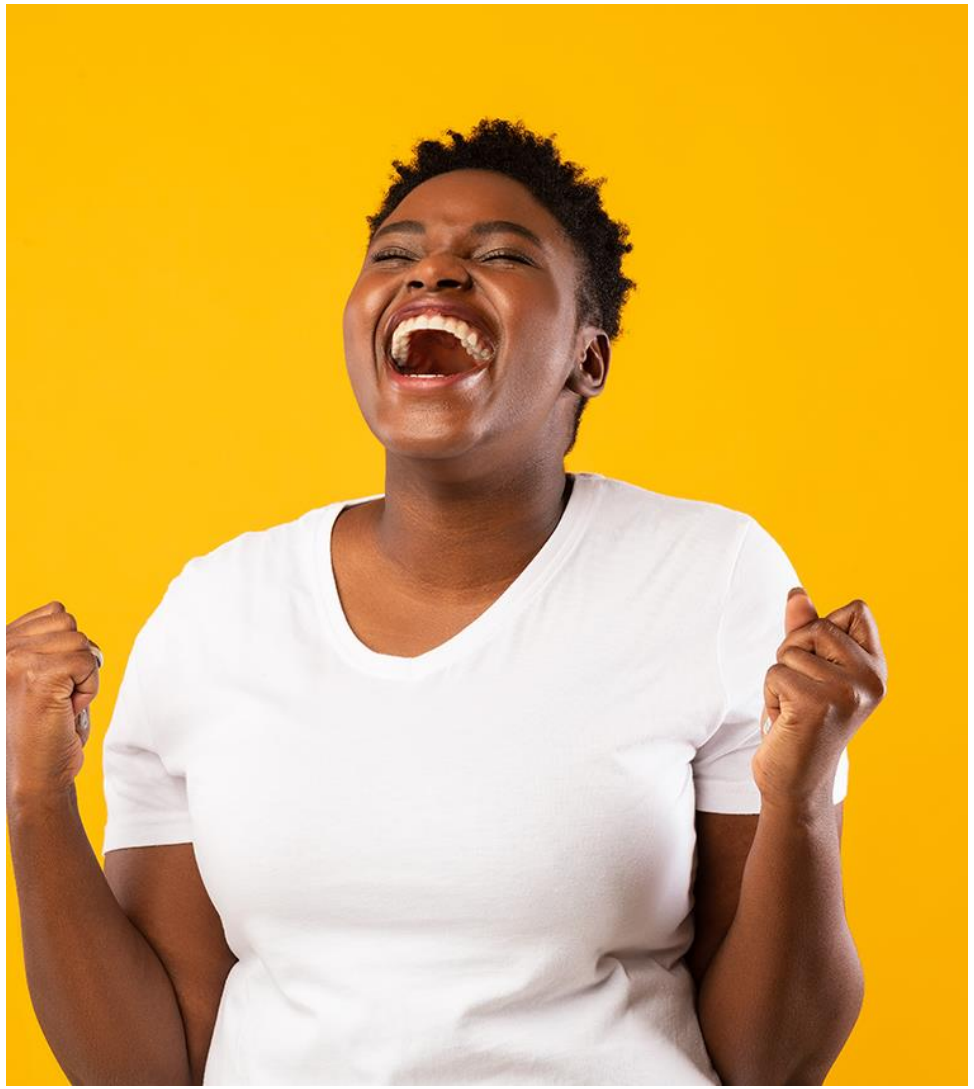
- Weakness
- Light-headed, dizzy
- Diaphoresis
- Blurred vision
- Nausea
- **Feeling warm or cold**
- **Sudden need to go to the bathroom**
- Facial pallor
- Yawning

Vasovagal Prevention

- Anticipatory guidance
- Good hydration
- Eat before placement

How to Avert a Vasovagal

- Isometric contractions of the extremities
- Intense gripping of the arm, hand, leg, and foot muscles
- No need to change position- just tense the muscles
- **This stops the reaction**



Williams 2022; Hall 2016; Van Dijk 2006; Grubb 2005

Anticipatory Guidance

Many people having an IUD placed will feel dizzy and can even faint.
If that happens it can be scary!

But you can stop it from happening!

Anticipatory Guidance

If you start to feel light-headed, or nauseated, or if you just feel weird in any way… tense the muscles in your hands, arms, feet, and legs and it will stop. Would you try it now--to practice?

During IUD Placement

- Ask for consent to proceed
- Cervical anesthesia
- Distraction
- Verbicaine
- Inhaled lavender
- Ultrasound guidance
- Use of instruments
- Slow technique

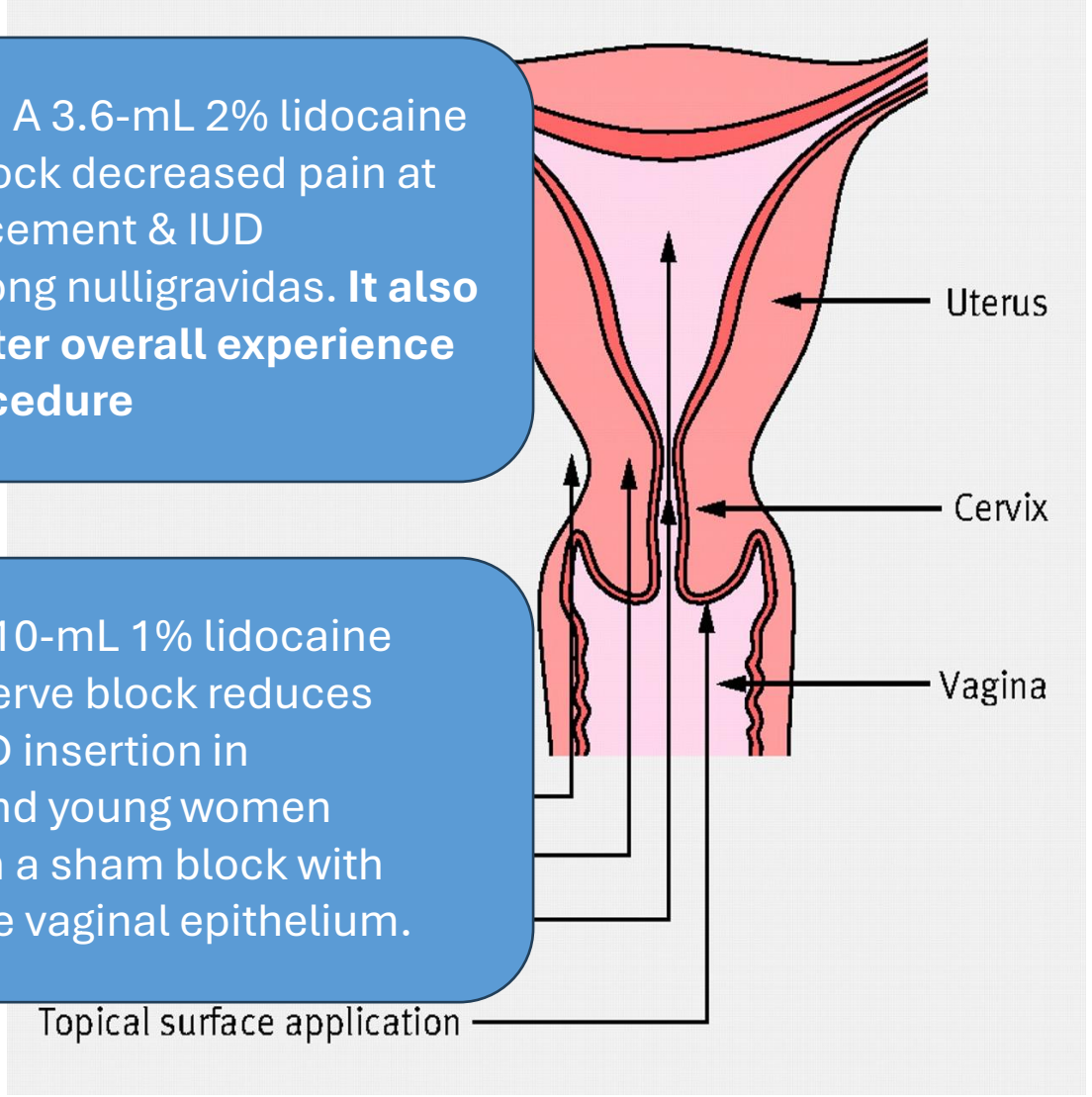
Cervical Anesthesia

From Mody: A 20-mL buffered 1% lidocaine paracervical block decreases pain with IUD placement, uterine sounding, and 5 minutes after placement. Although paracervical block administration can be painful, perception of pain for overall IUD placement procedure is lower compared with no block

From de Oliveira: Lidocaine intracervical block was found to be more effective than naproxen in reducing placement pain

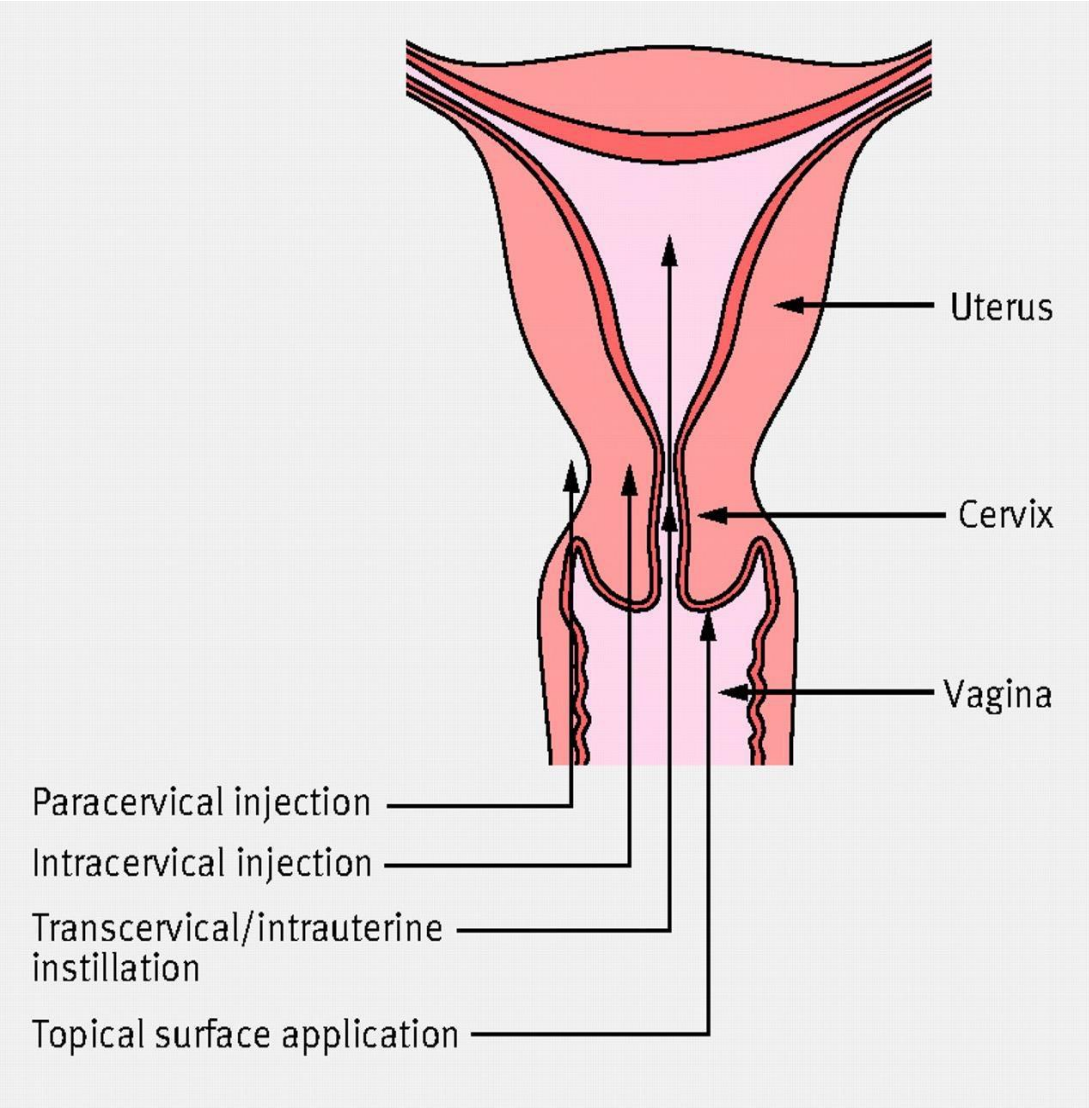
From De Nadai: A 3.6-mL 2% lidocaine intracervical block decreased pain at tenaculum placement & IUD placement among nulligravidas. **It also provided a better overall experience during the procedure**

From Akers: A 10-mL 1% lidocaine paracervical nerve block reduces pain during IUD insertion in adolescents and young women compared with a sham block with pressure on the vaginal epithelium.



de Oliveira 2021; De Nadai 2020;Mody 2018; Akers 2017

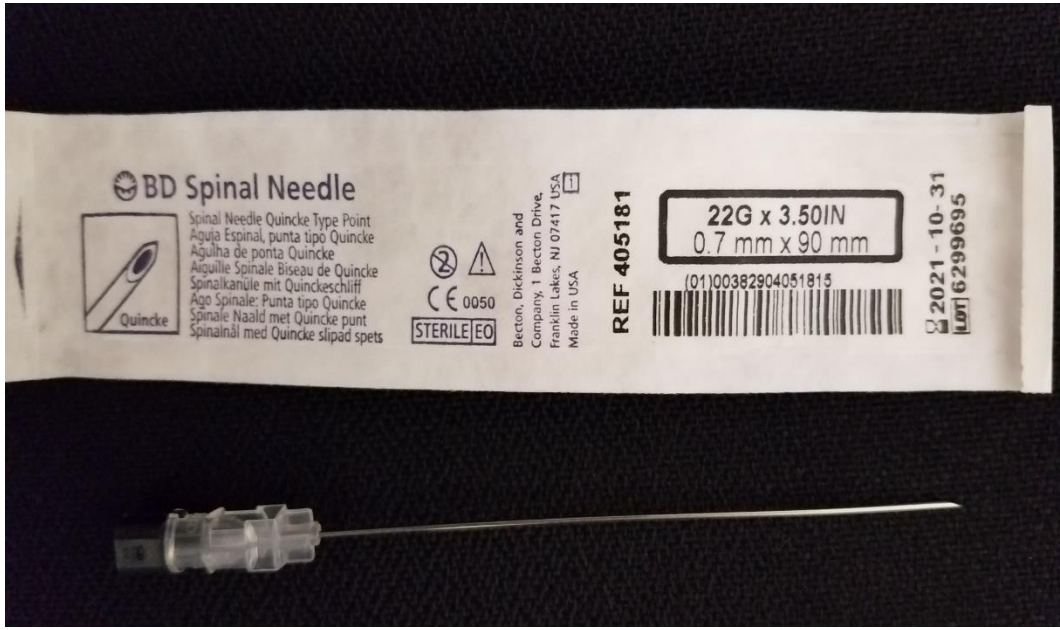
Cervical Anesthesia



Supplies for Cervical Blocks

- Needles
  - Use a spinal needle

    or
  - 25g, 1 ½" needle + extender
- +/- buffering at 1:5-1:10 ratio
  - Mixed data regarding the benefit of buffering with sodium bicarb at 5:1 or 10:1 ratio
- Lidocaine 1% or 2% **without epinephrine**

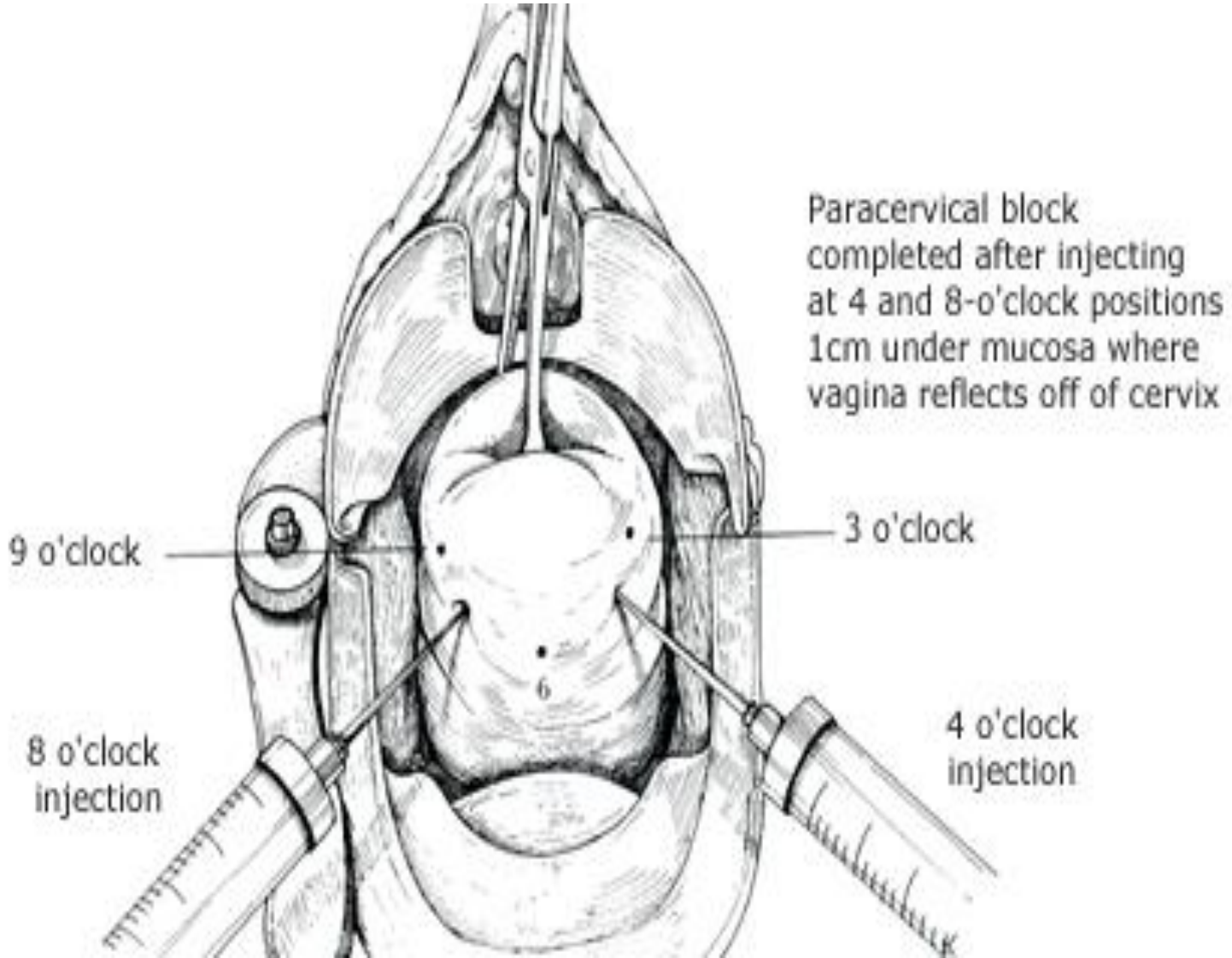


Tenaculum Blocks

- Inject ½- 1 cc. at 12 o’clock for anterior lip placement (or 6 o'clock for posterior lip placement)
- Then apply tenaculum

Paracervical Block

- Inject at the reflection of cervicovaginal epithelium
- Target is uterosacral ligaments, which contain the cervical and uterine nerves

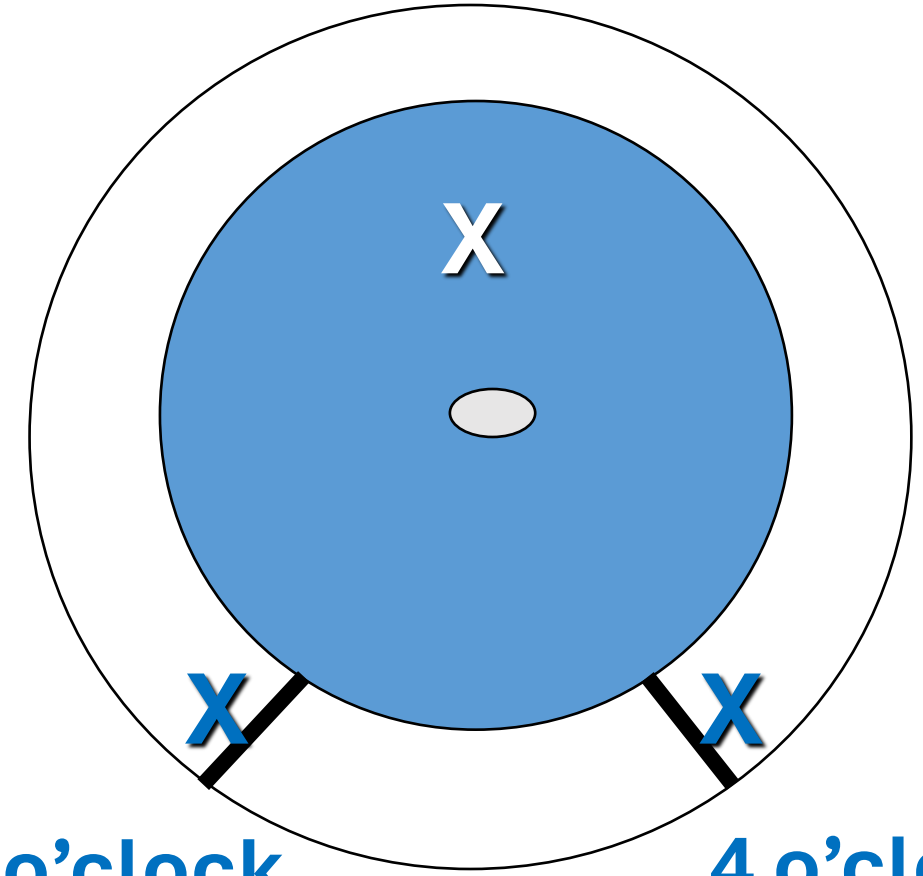


Paracervical Block

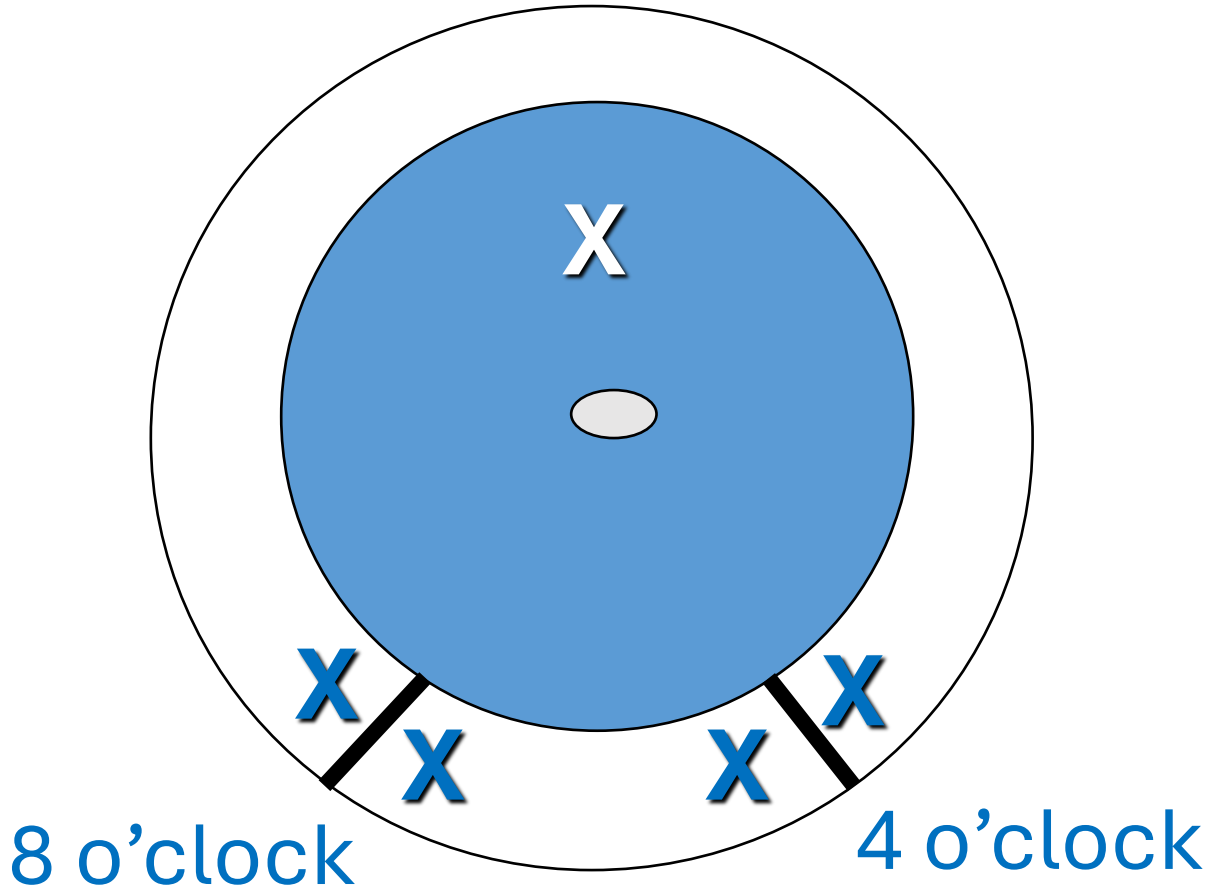
- 5-10 cc 1% lidocaine (no epinephrine) each side
- Submucosal injection 1.5cm-3cm deep
- Short speculum allows for more movement
- Mixed data on how long to wait, if at all, after administering lidocaine. Standard has been to wait 1-2 minutes after placing block
- For abortion care, evidence for 2 site injection
- Mixed data on 2 vs 4 sites of lidocaine administration in IUD specific studies

(Curtis 2024; Renner 2024)

Paracervical Block



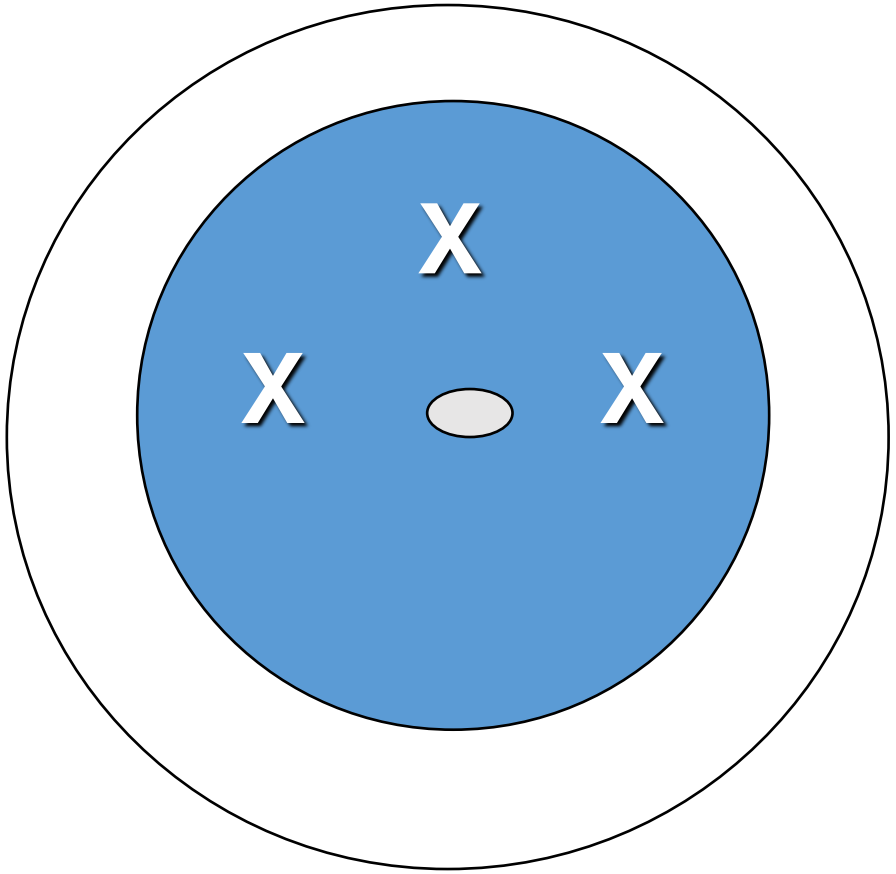
Paracervical Block



Intracervical Block

Targets the paracervical nerve plexus

9 o'clock



3 o'clock

1-2 cc lidocaine (no epinephrine) at 3, 6, 9 o'clock, injected approx. 1.5 inches deep

(De Nadai 2020; de Oliveira 2021)

Lidocaine Safety

- Inject in the correct spot
- Aspirate to avoid intravascular injection
- Metallic taste is a common side effect
- Common trigger for vasovagal
- Indications of intravascular lidocaine injection:
  - Early symptoms: circumoral numbness, tongue paresthesia, dizziness
  - Sensory symptoms: tinnitus and blurred vision
  - Excitatory sign: agitation

Topical Medications

- 10% Lidocaine spray (Wait 3+ min for the lidocaine to take effect)
- Lidocaine-prilocaine cream 5%
- 2% lidocaine gel is not effective. However, Conti et al., found that **patients were willing to extend visit time to gain pain control & that self-administration of local anesthetic was acceptable to patients.**
- Intrauterine instillation
- Evidence on intrauterine instillation of a local anesthetic generally suggested no positive effect on patient pain.

Curtis 2024; Conti 2019; Lopez Cochrane review 2015; Abbas 2021; Fouda 2016; Rapkin 2016; Panichyawat 2021; Aksoy2016

Distraction by any Means…

McCarthy 2018

Verbicaine for Distraction

- Keep the patient talking about something (anything) they are interested in
  - Hobbies, work, kids
- Calm, soothing vocal tone
- Slow, easy pace – to signal to the patient that there is no time pressure

Daykan 2020

Inhaled Lavender

- One study showed inhaled lavender significantly reduced anxiety associated with IUD placement compared with the placebo control group
- Another showed inhaled lavender significantly reduced anxiety associated with intrauterine insemination compared with the placebo control group

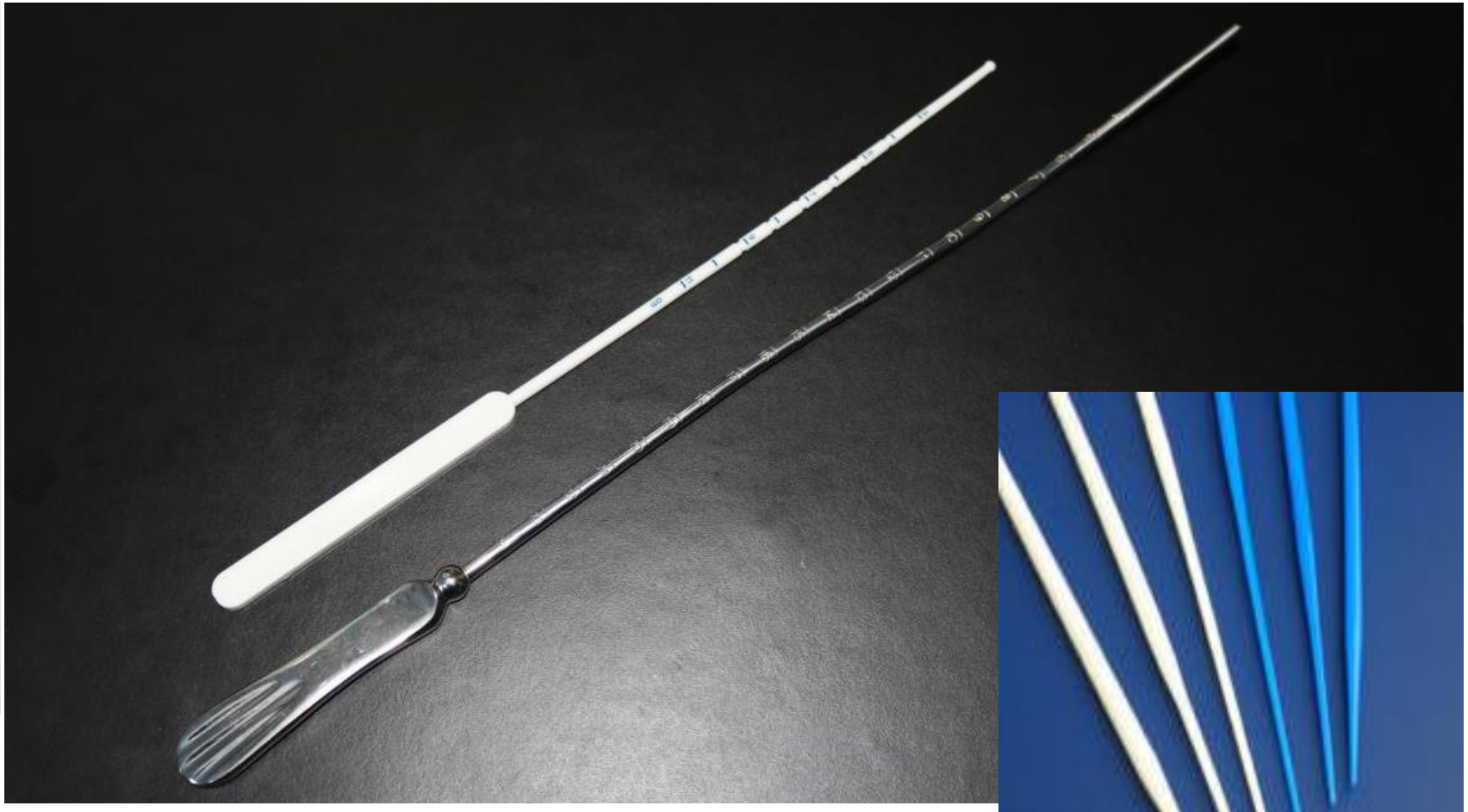
Jones 2021;Shahnazi 2012

Ultrasound Guidance During IUD Placement

- Not standard of care
  - U.S. vs. Europe
- Helps with challenging placements
- Possibly fewer malpositioned devices (unknown clinical significance)
- Can reassure patient & provider-- particularly in teaching environments

Baradwan 2023; Maged 2021

Use of Instruments



Speculum

- Select a shorter speculum whenever possible
- Avoid a long speculum, which can splint the cervix and prevent movement of the cervix when using the tenaculum
- Use a WIDER speculum, if necessary, NOT longer
- When using a small speculum and unable to view os:
  - Grasp whatever portion of the lip of the cervix presents itself, and then use the tenaculum to bring the os into view
- Warm the speculum before use
- Don’t keep it in the vagina for longer than needed

Tenaculum Alternatives

- Use of an “atraumatic tenaculum” --Allis or vulsellum is not shown to be associated with different levels of pain than a single-tooth tenaculum

Doty 2015

Tenaculum Alternative

- A suction cervical stabilizer recently cleared by the FDA
- Pain scores lower than in the tenaculum group
  - Cervix grasping (14.9 vs 31.3),
  - Traction (17.0 vs 35.9)
  - IUD placement (31.5 vs 44.9)
  - Cervix-release (20.6 vs 30.9)
- 32.8% of devices had defects. The most common issue was with the slider
- > 1 positioning attempts were necessary in 23%
- Spontaneous device releases in 38%
- Switched to tenaculum in 18%

1. *Place it on the cervix, and press the button to create a vacuum*
2. *Pull the plunger to create a vacuum and rotate it to lock it in position*
3. *Allow 10 seconds before cervix manipulation*

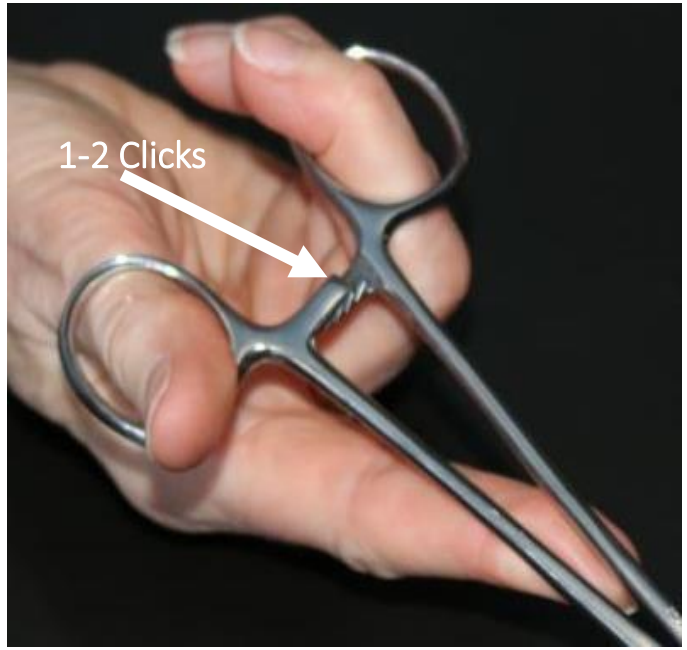
Yaron 2023

Tenaculum: Size of Bite

- 1-1.5 cm wide
- 1 cm deep
- Not too shallow- may tear through
- Not too deep- unnecessary and more painful

Tenaculum: Closing Ratchet

- Once the teeth are in contact with the cervix, press into the tissue
- Close the ratchet only 1-2 clicks
- Close the ratchet silently
- Once the ratchet is closed, test your application gently to be sure it is secure



Tenaculum: Options to Reduce Pain

- 1cc local anesthetic to the tenaculum site with a block

and/or

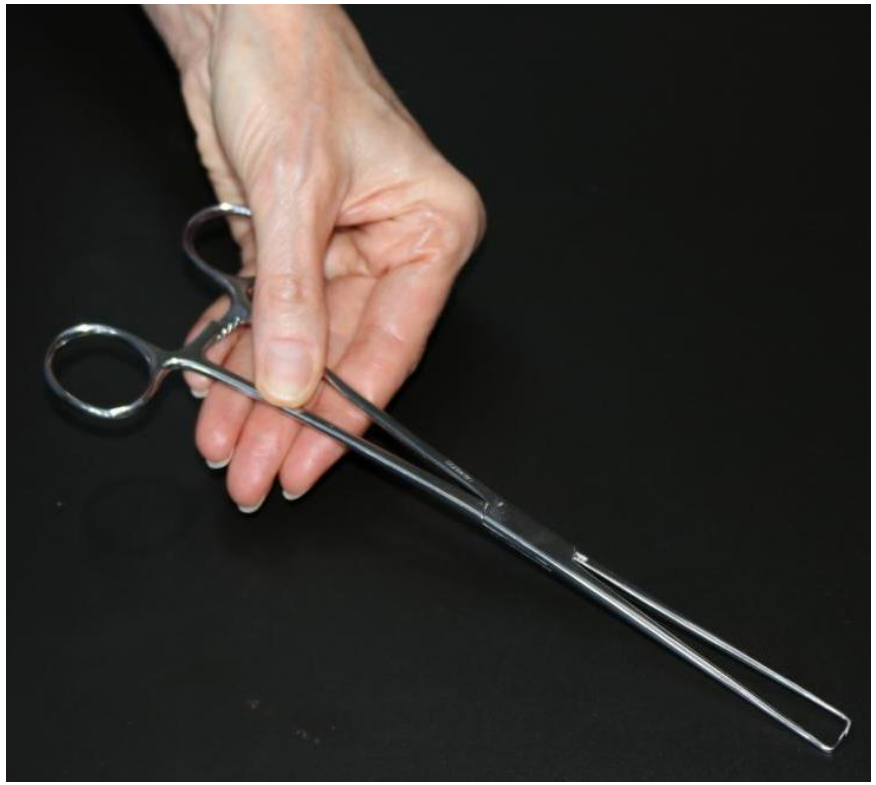
- Squeeze teeth together EXCEEDINGLY slowly

and/or

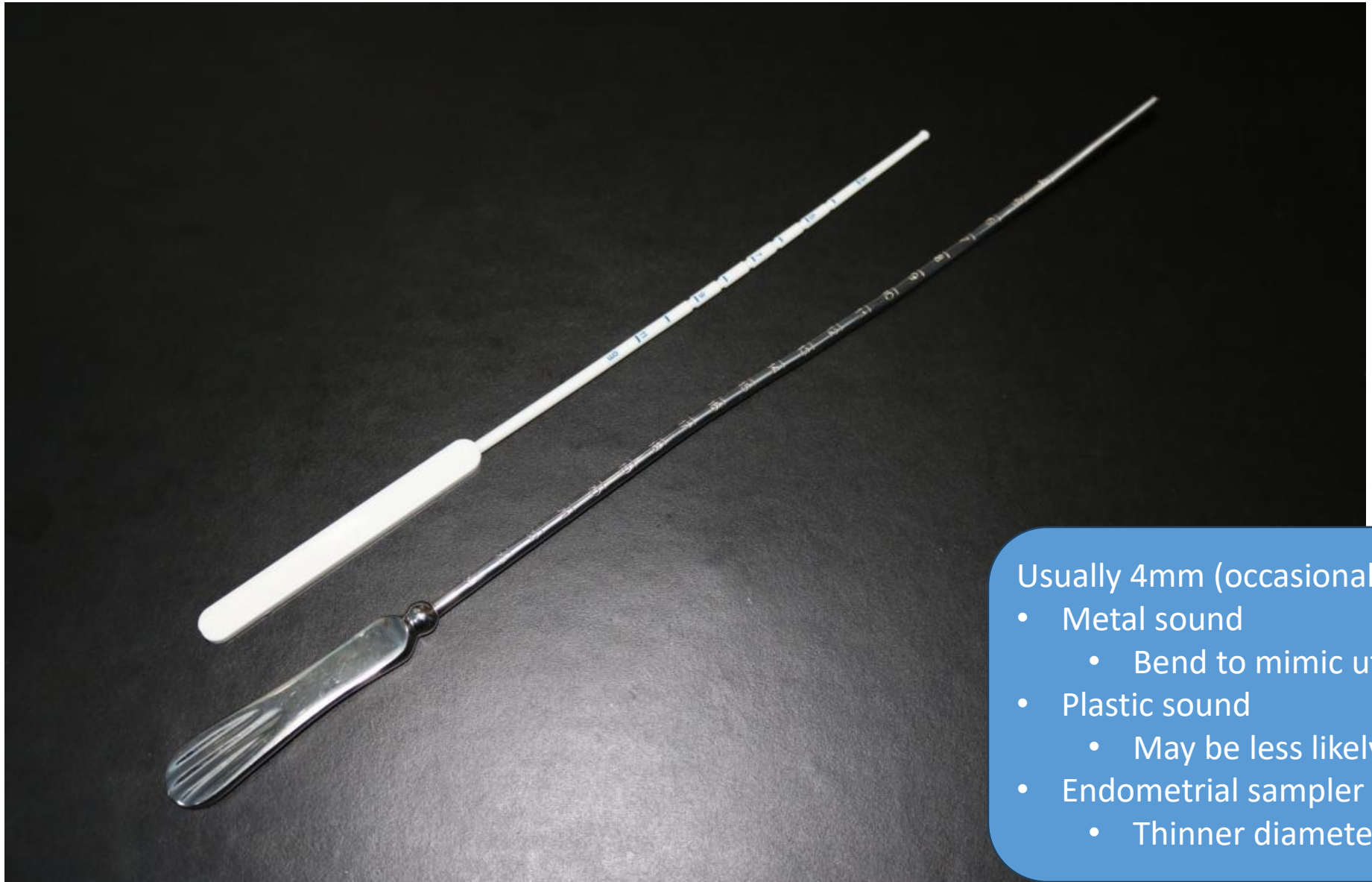
- Have patient cough at application (hold onto speculum!)

Tenaculum: When Sounding and Placing IUD

- Thumb on one side of ratchet and fingers on the other
- **DO NOT** move the tenaculum inadvertently
  - Avoid placing fingers in the rings to avoid inadvertent movements
  - OK to let tenaculum rest on speculum when picking up the sound or IUD



Uterine Sound…Which One?

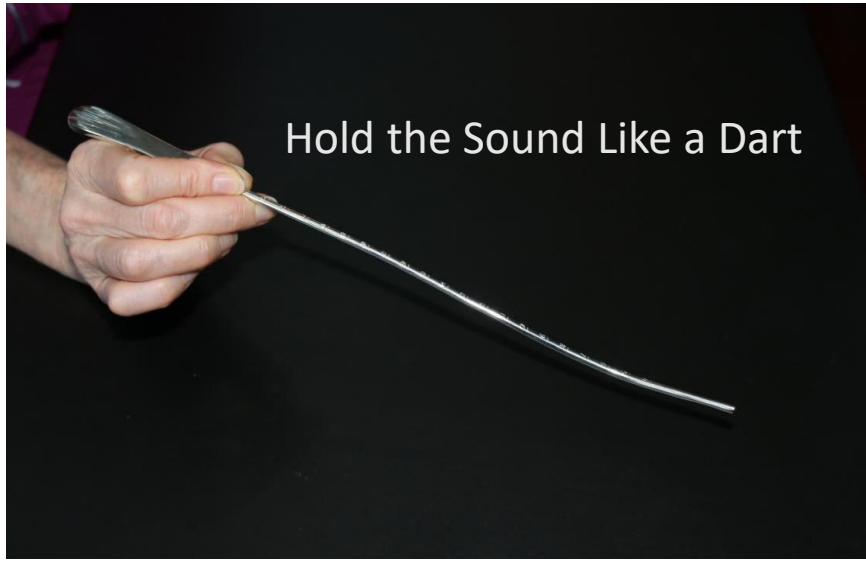


Usually 4mm (occasionally 3mm)

- Metal sound
  - Bend to mimic uterine flexion
- Plastic sound
  - May be less likely to perforate
- Endometrial sampler
  - Thinner diameter

Prevention of Pain and Perforation with Sound

- Perforation often hurts and is anxiety-provoking
- Careful assessment of uterine position
- Some clinicians prefer to measure the uterus with ultrasound instead of a sound –associated with pain reduction
- If using a metal sound, bend the distal 6-8 cm to mimic uterine flexion
- Exert adequate traction with the tenaculum
- **Go slow**
- Use **finger or wrist action**- not elbow or shoulder muscles



Ali 2022; Cason 2016

Prevention of Pain and Perforation with Sound

- Don’t push hard or use force at the internal os
- Slow progression through the internal os
- Once you have passed through the internal os—**STOP** and pause for a second
- Then intentionally proceed to the fundus in a controlled fashion
- Avoid momentum

Golden Rule to Prevent Pain

- Move Slowly and intentionally
- Moving too quickly increases discomfort
- Consider an endometrial biopsy (EMB) sampler or a smaller plastic sound
- Touch the fundus once --repeated tapping is unnecessarily uncomfortable for the patient

Difficulty Passing Through the Os

- Offer cervical block and consider ultrasound guidance
- Change the direction of traction or position of the tenaculum
- Gently hold the sound at the internal os and then **wait** --to allow the os to yield
- Change the curvature of the sound (if metal)
- Apply light pressure at various angles 360^{o} and positions with the sound looking for an opening
- Approach more anteriorly or posteriorly

Still Unable to Pass Through Os?

- Use an os finder device or use a thinner sound (endometrial sampler)
- Or dilate internal os with a small dilator
- If replacing the tenaculum:
  - Also try a shorter wider speculum
  - Reposition the tenaculum onto a different place or add a second tenaculum
- Return after misoprostol 200 mcg per vagina 10 & 4 hours prior to placement. Buccal misoprostol administration is not effective

Tassi 2020;Bahamondes 2015

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Thank you.
Questions?

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