The 7-2-1 Episode 3

Dr. Durant: Welcome to the third installment of our podcast series – "7/2/1- All that you need to know about periods"

I am Nefertiti Harmon Durant an Adolescent Medicine physician in the Female Adolescent Bleeding Clinic Division in the Department of Pediatrics at the University of Alabama at Birmingham and a proud member of the Foundation of Women and Girls with Blood Disorders (or FWGBD).

I have the pleasure of introducing my wonderful colleague and co-host– Dr. Sweta Gupta, Pediatric hematologist at the Indiana Hemophilia and Thrombosis Center at Indianapolis and a member of the Foundation for Women and Girls with Blood Disorders' Medical Advisory Committee. We both share a common passion for taking care of young girls with heavy menstrual bleeding.

Dr. Gupta: It is great to be back Dr. Durant.

Dr. Durant: I am so pleased that we are joined by– Dr. Claudia Borzutzky to discuss Demystifying IUDs. Dr. Bortzutsky is an Associate Professor of Pediatrics at the Keck School of Medicine of USC, and. the Adolescent Medicine Fellowship Program Director at Children's Hospital Los Angeles, or CHLA. Dr. Borzutzky co-directs CHLA's combined hematology-adolescent medicine clinic and leads the Division of Adolescent and Young Adult Medicine's full-scope contraception service to adolescents and young adults, which includes provision of long-acting reversible contraceptives such as intra-uterine devices and subdermal implants. She is an active member of the Sub Committee of Education and Advocacy on the FWGBD.

Dr. Durant:
To recap Part 1 of Demystifying Intrauterine Devices or IUDS, we discussed -

- Options for IUDS
- What can most patients expect from the IUD with regards to change in menstrual bleeding
- How likely is it that their bleeding will stop and if not, will they still

have a regular period
- Is the change in bleeding similar for patients with a bleeding disorder

Dr. Gupta:
- Management of breakthrough bleeding in the setting of an IUD
- Complications associated with having an IU
- Rates of IUD expulsion and is it different for patients with and without a bleeding disorder

Dr. Durant: Let's get started!

Dr. Durant: If an adolescent with heavy menstrual bleeding wants to be treated with an IUD, can it be placed in the outpatient setting, or does it need to be done under anesthesia?

Dr. Borzutzky: Most people, teenagers included, are able to have their IUD placed while awake and in a standard outpatient medical office. While having a pelvic exam may be new to many teens, generally they tolerate the IUD insertion procedure well, and there is no data to support restricting the procedure to those who are parous or have been sexually active. There is also no minimum age to be considered a good candidate for IUD, though the patient does need to be post-menarchal.
It is our collective experience that even teens who have never had anything in their vagina before (tampons included) can tolerate an awake IUD insertion procedure, particularly if it is accompanied by calm reassuring language, assistance with relaxation, and distraction. The experience, severity, and duration of the colicky, visceral type of pain associated with the cervico-uterine manipulation involved in IUD insertion is highly variable and does not correlate with parity. NSAIDs, if not contraindicated, or other oral analgesics, are often given at the start of the procedure, but they are really being given to help mitigate the crampy pain that patients will feel after the procedure -- not the pain experienced during the procedure itself. Though cervical blocks using lidocaine have been demonstrated in some studies to reduce the pain associated with IUD insertion, they are not universally used as other studies have not supported this claim. For patients who have failed an awake procedure attempt, or for those who have severe procedural anxiety, general anesthesia or "twilight" anesthesia should be considered; in some cases, a low dose oral anxiolytic can also

be trialed prior to insertion. However, the risks and benefits of using these additional interventions must be weighed, particularly given that the entire IUD insertion procedure typically takes 5-10 minutes or less.

Dr. Gupta: What can patients expect post-insertion, in terms of pain?

Dr. Borzutzky: While some patients will experience intermittent crampy pain for several weeks following IUD insertion, or even several months, most patients report that after 1-2 days it largely subsides. Again, NSAIDS including celecoxib can be recommended or prescribed, if needed, as well as the use of warm packs. Severe abdominal pain associated with nausea, vomiting, or localizing symptoms, can be indicative of a uterine perforation, and patients should be advised about these warning signs.

Dr. Durant: Do IUDs have any impact on future fertility?

Dr. Borzutzky: The IUDs currently in use have no detrimental causal effect on future fertility, and therefore can be offered to patients along any point of their reproductive life. In the past, they were offered primarily to parous women due to the potential for increased risk for pelvic inflammatory disease and associated threats to fertility, due to the type of materials used in the IUD strings. However, with our current IUDs, if testing for gonorrhea and chlamydia is performed at the time of insertion, and if identified infections are treated promptly, once the IUD has been in place for 30 days the risk for PID is the same as for patients with no IUD.
It is our experience that many patients, particularly those from communities that have been subjected to reproductive injustices such as coercive use of LARC methods or sterilization as a means of population control, tend, understandably, to approach contraception in general with a much higher degree of skepticism than those from communities who have not been subjected to these highly unethical practices. LARC methods, given that they are harder for users to start and stop (as opposed to user-controlled methods like pills, patch, ring, or even injection, tend to be viewed with even more suspicion. We must always remember that it is not our job to convince patients to choose one contraceptive method vs. another, but rather, to provide them with as much accurate information as we can, so that they can make a truly informed choice. I find that if I acknowledge this history of reproductive injustice openly and honestly, and with humility

about the mistakes our profession has made, it can help to build a foundation for trust and better exchange of information.

Dr. Gupta: What about the effect on fertility of stopping periods? Patients and their families also often express worries that this is "not natural," and that the body is losing its means of cleaning itself.

Dr. Borzutzky: As Tricia mentioned earlier, the reason that menstrual periods become much lighter and less frequent, or stop altogether when using hormonal IUDs, is that the progestin being released causes the endometrium, or lining of the uterus, to become extremely thin and "dormant." I often explain this to patients using a diagram or picture. Further, I explain that this is completely reversible – and that the lining will build back to its natural thickness shortly after the IUD is removed, and that by the same token, their fertility will return quickly. In fact, we inform patients who are sexually active that if they do not want to get pregnant, they should use an alternate form of contraception immediately after removing their IUD.

Dr. Durant: What are the possible side effects associated with IUD use, over time? My patients are always concerned about weight gain and acne. Are these issues?

Dr. Borzutzky: First, it's important to know that because the levonorgestrel, the progestin released by the hormonal IUDs, is absorbed mostly at the level of the uterus, and leads to much lower circulating levels of hormone than with other contraceptive methods, the likelihood of side effects at a location located remotely from the uterus are much lower with the IUD than with those other methods. The IUD has not been associated with weight gain, and though we don't have great data about acne, in our experience it's also very unlikely.

Dr. Gupta: The most frequent complaint from patients is breakthrough bleeding. How often does it occur and when can we tell patients it will stop?

Dr. Borzutzky: The MOST common side effect reported with the hormonal IUDs is, as we have discussed, changes to the menstrual cycle. For some patients, they will have more frequent and sometimes heavy bleeding in the

first few months after placement of the IUD, but for most, that will slow down substantially by 6 months, and for most, they will have less frequent and much less heavy menses, depending in part on which hormonal IUD was used.

Dr. Durant: I am frequently asked about infection. Is this a concern? Do IUDs increase the risk of STI's (or a sexually transmitted infection)?

Dr. Borzutzky: Another concern people sometimes have is related to infection risk with IUDs. Having an IUD does not increase one's risk of getting sexually transmitted infections such as gonorrhea or chlamydia. However, if one of those micro-organisms are present at the time of IUD insertion, there is an increased risk of developing an ascending infection, or pelvic inflammatory disease (PID), so as noted earlier, standard of care is to test for those at the time of infection. If it is treated within one week's time, the risk of PID is not increased relative to the general population. Additionally, if the medical provider can see evidence of an active cervical infection when preparing them for an IUD insertion, then the IUD insertion should be rescheduled until after treatment has been completed.

Dr. Durant: Can you comment on Pokey Strings - many patients report their male partners report discomfort from the strings of the IUD. What do you recommend for management?

Dr. Borzutzky: There are a couple of other things that patients sometimes worry about or do come in for guidance for. One is the issues of "pokey strings." Occasionally patients who are sexually active with male partners will report that their partners have experienced discomfort because their penis is being "poked" by the ends of the IUD strings. This can almost always be managed by the provider, either by trimming the strings, or by tucking them back around the cervix. Additionally, the strings do tend to soften over time, so for patients who do not want another speculum exam, some reassurance that this will likely improve will go a long way. Or another great reason to use a condom! Condoms might decrease the irritation caused by the strings.

Dr. Gupta: Many patients ask about tampon use with IUDs. I typically tell patients that tampon use is fine. What advice do you give? Are there

educational sites to provide on menstrual care with IUDs?

Dr. Borzutzky: Use of tampons is perfectly fine once an IUD is in place and removing the tampon should not pull the IUD out – as long as the IUD is correctly placed, and the strings were not left excessively long.

Dr. Durant: Ok – last question…Is there anyone who cannot get an IUD?

Dr. Borzutzky: So, very few people are unable to get a hormonal IUD, particularly if they are a teenager or young adult – since they are very unlikely to have cervical or uterine cancer, both of which are contraindications to IUD insertion. For young people with known Mullerian anomalies (including a unicornuate and bicornuate uterus), IUDs are contraindicated, particularly if they are being used for contraception, since the IUD may not reach the fundus properly in the case of a differently shaped uterus. If the provider can't be reasonably sure that the patient is not pregnant, then they should also postpone the IUD insertion until they can be. And as noted above, if there is a clinically apparent cervical or uterine infection, then the IUD insertion should be postponed. Lastly, if the patient has unexplained vaginal bleeding not consistent with a normal menstrual period, that has not yet been evaluated, since hormonal IUDs can cloud that picture further, IUD insertion should be delayed -- until that evaluation has been completed.

Dr. Gupta: Thank you very much for this wonderful information.
Please come back for our next episode of the 7-2-1 – a podcast about periods and everything related.
For more information on heavy menstrual bleeding, please visit the FWGBD website (fwgbd.org).