Title

Non-Palpable Contraceptive Implant Removals: Experience From a Referral Center

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INTRODUCTION: The American College of Obstetricians and Gynecologists (ACOG) recommends LARC use as first line for all reproductive aged women who desire contraception, including women that are in the immediate postpartum period. There are no studies that describe the preference of Arizona women to use LARC during the immediate postpartum period and their ability to obtain their preferred contraception.

METHODS: This was a prospective cohort study that used postpartum phone surveys at 2, 6 and 12 months to inquire about postpartum follow up compliance, contraception choice at time of delivery, and ability to achieve and maintain their method of choice.

RESULTS: 79 patients were recruited at Banner University Medical Center Tucson. During their delivery hospitalization, 49% expressed desire for a LARC. 28% received a LARC, 41% definitively did not receive one, and 31% were lost to follow up. Of those not using a LARC at follow up, only 43% were using an effective method. In those who had at least one follow up call, the pregnancy rate was 9 percent (n=5). 4 pregnancies were unintended, and 3 of these patients had desired a LARC but did not receive one. 76% of all patients reported contraception counseling prior to delivery hospitalization. Individuals who received pre-delivery discussion were twice as likely to desire a LARC at time of delivery.

CONCLUSION: Far more individuals desire LARC than those who receive LARC. Even women who are strongly motivated to avoid pregnancy are at risk of unplanned pregnancy within the first year after delivery.

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Malposition and Expulsion of Immediate Postplacental Intrauterine Devices [3P]

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INTRODUCTION: The primary objective was to determine if immediate postpartum placement of intrauterine devices at time of cesarean delivery was associated with increased rates of malpositioned devices compared with placement after vaginal delivery.

METHODS: This was a retrospective cohort of 126 women who received immediate postpartum intrauterine device placement (either a postplacental levonorgestrel or copper) following vaginal or cesarean delivery over a two year period between May 2015 to May 2017 at a tertiary care center. Women were followed for 12 weeks postpartum.

RESULTS: A total of 126 women were analyzed in this study (N=63 for vaginal deliveries and N=63 for cesarean delivery). Baseline demographic characteristics between the vaginal delivery and cesarean delivery groups were similar. The total discontinuation of IUD secondary to malposition or expulsion was 33% (N=42; 25% at time of cesarean delivery versus 41% at time of vaginal delivery) at 12 weeks post-partum. Expulsion of the IUD was significantly more common in the vaginal delivery group (31.7% versus 12.7%, p=0.017). There was no difference in malposition between the two groups (9.5% in vaginal delivery group, 14.2% in cesarean delivery group, p=0.58). There was a significant increase in use of ultrasound to determine IUD position amongst the cesarean delivery group (46.0% vs. 12.7%, p=0.00003).

CONCLUSION: Immediate post-placental IUD placement after vaginal delivery resulted in a higher occurrence of expulsion than following cesarean delivery. We did not observe a significant difference in malposition of intrauterine devices following placement after vaginal delivery compared with cesarean section.

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Medroxyprogesterone Eliminates Abnormal Bleeding With a Levonorgestrel Intrauterine System (LNG-IUS) [4P]

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INTRODUCTION: Abnormal vaginal bleeding is a common side effect seen in the majority of patients in the first six months after LNG-IUS placement. Some women may desire its removal because of this effect. The objective of this study was to assess the ability of medroxyprogesterone (MP) to reduce this initial bleeding transition period.

METHODS: We prescribed a tapering regimen of medroxyprogesterone (MP) overlapping the first 35 days with the LNG-IUS. Four women who desired amenorrhea adhered to this regimen: on day three of their menses, they began a 14-day course of MP 10 mg daily; on day four, the LNG-IUS was inserted; on day 17, the MP was reduced to 5 mg daily for ten days; on day 27, the MP was reduced to 2.5 mg daily for ten days. The women were given a diary to record their bleeding pattern.

RESULTS: All four women (100%) became amenorrheic within seven days of LNG-IUS insertion and remained so for the duration of use with the LNG-IUS (>1 year). Three out of four (75%) recorded 3-5 days of spotting for the first 1-4 months with the LNG-IUS.

CONCLUSION: Our tapering regimen of MP overlapping the first 35 days with an LNG-IUS is sufficient to eliminate the initial period of abnormal bleeding. Iatrogenic amenorrhea may alleviate many patients' feelings of anxiety as well as other menstrual symptoms, and this may affect a patient's decision to continue using the LNG-IUS. More research is required to validate this study.

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Non-Palpable Contraceptive Implant Removals: Experience From a Referral Center [5P]

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INTRODUCTION: To describe our experience as a non-palpable contraceptive implant referral center, including office removal of subfascial implants.

METHODS: We reviewed the charts of 46 patients seen in our Family Planning subspecialty center for non-palpable contraceptive implant removal from March 2015 through August 2018. Non-palpable implants were localized using high-frequency ultrasonography and skin mapping. We extracted information on demographics, implant location, and outcomes. We used Fisher exact testing for dichotomous variables. IRB-approved.

RESULTS: Five women had palpable implants of which four chose to have removal. Ultrasound localization was performed for the other 41 women; one was not visualized and was identified on computed tomography imaging. Implants were intrafascial (n=1), suprafascial (n=15), and subfascial (n=25). The patient with intrafascial placement chose to continue use. Two patients with a subfascial implant opted to delay removal. We completed all 15 attempted suprafascial implant removals and 19/23 (83%) attempted subfascial removals in the office. Three of the four failures had removal in the operating room with a collaborative orthopedic surgeon; the other patient sought surgical removal elsewhere. Post-procedure neuropathic pain complaints were reported after 7 (30%) subfascial and no suprafascial removals (P=.03). Non-palpable implants were subfascial in 1/8 (12%) obese and 24/33 (73%) non-obese women (P=.003). Eight (32%) subfascially located implants were inserted during a removal-reinsertion procedure through the same incision.

CONCLUSION: At a specialized referral center, most subfascial implants can be removed in the office; some patients may experience limited post-procedure neuropathic pain. Most non-palpable implants in non-obese women are subfascial and in obese women are suprafascial.

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Pain Medication Use in Opiate Dependent Patients During Surgical Abortion [6P]

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