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CONTINUATION OF COPPER AND LEVONORGESTREL INTRAUTERINE DEVICES: A RETROSPECTIVE COHORT STUDY

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Objectives: We aimed to assess continuation rates and performance of levonorgestrel intrauterine devices (LNG-IUDs) compared with copper intrauterine devices (Cu-IUDs) over a 5-year period.
Methods: We performed a retrospective cohort study of women who underwent IUD placement at affiliated sites of an urban academic medical center. The analysis compared continuation rates between LNG-IUD and Cu-IUD, factors associated with discontinuation and IUD performance. We assessed differences in continuation at 2, 4 and 5 years and pregnancy and expulsion rates using chi-square tests. We compared proportions using chi-square tests and calculated hazard ratios using a multivariable Cox model.
Results: Of 1325 women who underwent IUD placement, 1104 had follow-up data available. At 2 years, 62% of LNG-IUD users continued using their device, compared with 57.7% of Cu-IUD users (p=.34). At 4 years, continuation rates were 40.5% for LNG-IUD users compared with 32.6% for Cu-IUD users (p=.09), and at 5 years, continuation rates were 25.2% for LNG-IUD users compared with 23.8% for Cu-IUD users (p=.74). The hazard ratio for discontinuation of LNG-IUD compared with Cu-IUD was 0.90 (95% CI, 0.70–1.14) after adjusting for race, age, parity and education. Black race and primiparity were positively associated with IUD discontinuation; age and education were not. Cu-IUD users were more likely to experience expulsion (10.2% Cu-IUD users vs. 4.1% LNG-IUD users, p<.001) and to become pregnant (first-year pregnancy rate 1.6% of Cu-IUD users vs. 0.1% LNG-IUD of users, p=.002).
Conclusions: We found no difference in continuation rates between LNG-IUD users and Cu-IUD users. Women using Cu-IUDs were more likely to experience expulsion and pregnancy.

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METHODS OF CONTRACEPTIVE PROVISION AND THE UPTAKE OF LONG-ACTING REVERSIBLE CONTRACEPTION

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Objectives: We aimed to compare differences in the contraceptive method chosen between women receiving structured contraceptive counseling alone and women receiving structured contraceptive counseling plus health care provider education and cost support for long-acting reversible contraception (LARC).
Methods: We compared women receiving contraceptive counseling alone (Phase 1) with women receiving "counseling plus" (Phase 2) at three federally qualified health centers using a controlled time-trend study design. The preferred method after counseling and at the end of the appointment was obtained. For women who chose a LARC method, we recorded if the method was provided on the same day. We used Poisson regression with robust error variance to estimate relative risks.
Results: We enrolled 1025 women; 508 in Phase 1 and 517 in Phase 2. Women in Phase 2 were more likely to choose a new contraceptive method than women in Phase 1, 71.6% versus 51.2% (RR, 1.39; 95% CI, 1.26–1.55). Phase 2 participants were more likely to choose a LARC method, 54.9% versus 31.3% (RR, 1.80; 95% CI, 1.54–2.10) and receive a same-day insertion, 34% versus 9% (RR, 3.60; 95% CI, 2.13–6.08). Some 291 women (28%) did not receive their chosen method on enrollment day; the most common reasons were that their health care provider did not have enough time (37%) and need to return with menses (20%).
Conclusions: Women who received structured contraceptive counseling alone had lower rates of LARC method uptake than women who received counseling plus health care provider education and cost support. Interventions that focus solely on contraceptive counseling do not address other structural barriers to LARC method uptake such as cost and provider practices.

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DOES THE EXPECTATION OF PAIN WITH INTRAUTERINE DEVICE (IUD) INSERTION DIFFER BETWEEN THOSE WHO INITIATE IUD AND THOSE WHO DO NOT? A SURVEY OF ADOLESCENTS AND YOUNG ADULT WOMEN

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Objectives: Pain is commonly cited as a barrier to IUD uptake. Our objective was to determine if young women initiating IUD expect less pain with IUD insertion than those selecting other methods.
Methods: We enrolled women aged 14–24 initiating contraception at an adolescent-only Title X clinic. All participants rated expected IUD procedural pain on a scale of 0–10. Following the visit, IUD initiators also rated their actual pain with insertion. We compared differences in pain using nonparametric tests.
Results: Of the 172 participants enrolled, 29% initiated an IUD, 30% initiated an implant and 41% initiated other methods. The median age was 20; participants were ethnically and racially diverse (39.5% White, 40.1% Hispanic, 11% Black, 9.3% other), and the majority were nulliparous (92%). Compared with all other contraceptive initiators, IUD initiators were older (20.5 vs. 19.6, p=.03) and more likely to be White (54% vs. 33.6%, p=.01). The median anticipated IUD insertion pain score was 6.0, and median pain scores were similar for IUD, implant and all other contraceptive initiators (p=.55). After insertion, IUD initiators reported higher pain than they expected (median=7, p=.004). Despite this, 78% of IUD initiators reported that they would recommend the IUD to their friends.
Conclusions: Young women initiating other contraceptives do not anticipate more pain with IUD insertion than those who initiate IUD. Higher IUD insertion pain than anticipated did not result in low rates of endorsement. Although anticipated pain does not appear to be a barrier to IUD uptake, interventions to reduce pain may improve patients' IUD experience.

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IMPACT OF AN EARLIER POSTPARTUM VISIT ON INTRAUTERINE DEVICE INSERTION AFTER DELIVERY

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Objectives: We aimed to compare the proportions of women who have an IUD placed at the postpartum visit whose visit is scheduled at 6 weeks versus 2–3 weeks after delivery; we describe barriers to IUD placement at the postpartum visit; and compare IUD use by 3 months postpartum.

Methods: We performed a prospective cohort study comparing outcomes before and after our department implemented a policy changing postpartum visit scheduling from 6 weeks to 2–3 weeks after delivery. We reviewed electronic medical records for contraceptive method initiated at the postpartum visit and reasons for delay in IUD placement. We called participants at 3 months postpartum to record current contraceptive use.
Results: Among 210 and 231 women who attended a postpartum visit at 6 weeks or at 2–3 weeks, respectively, 65 (31%) and 66 (28.6%) women desired an IUD (p=.6). IUD placement occurred among 47 (72.3%) and 27 (40.9%) of these women at the postpartum visit (p<.01). The most common barrier to IUD placement at 6 weeks was insurance constraints (*n*=10, 55.6%). Barriers to IUD placement at 2–3 weeks postpartum included patient preference to wait (*n*=14), provider deferral (*n*=11), insurance constraints (*n*=8), insufficient procedure time (*n*=3) and vaginal laceration pain (*n*=3). By 3 months postpartum, overall IUD use was similar (24.2% and 24.9%, p=.91).
Conclusions: The proportion of women receiving an IUD is lower when insertion timing is changed from 6 weeks to 2–3 weeks after delivery in clinical practice. While some barriers may be modifiable, patient preference is a common reason for delay. By 3 months postpartum, IUD use is similar regardless of postpartum visit timing.

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ROUTINE AVAILABILITY OF IMMEDIATE POSTPARTUM LARC METHODS: EFFECT ON NURSING ATTITUDES AND PRACTICES

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Objectives: Nurses play an integral role in intrapartum and postpartum patient education. This study aims to assess the attitudes, knowledge and practices of labor and delivery and postpartum nurses regarding postpartum contraception and evaluate for changes in these measures 1 year after an institutional initiative allowing routine availability of immediate postpartum long-acting reversible contraceptive (LARC) methods.
Methods: In 2014, Montefiore Medical Center began an initiative to routinely offer comprehensive immediate postpartum contraception. The initiative included nursing educational and feedback sessions on postpartum contraception, including immediate postpartum initiation of a LARC method. Anonymous surveys were completed at the beginning of the initiative and repeated after 1 year. Descriptive statistics were obtained, baseline and 1-year results were compared using chi-square tests and multivariate regression was used to evaluate associations.
Results: The sample consisted of 59 nurses at baseline and 56 after 1 year. The proportion of nurses who stated they counseled patients on contraception always or most of the time increased from 46% to 71% (p=.005). The proportion who would recommend the IUD and implant for postpartum contraception increased from 2% to 32%, (adjusted OR, 20.7; p=.005). Attitudes toward the injectable for breastfeeding women remained negative: 46% at baseline and 61% at 1 year agreed with the statement that DMPA has a negative effect on breastfeeding.
Conclusions: Experience working in a location with routine access to immediate postpartum contraception is associated with increased awareness among nurses of postpartum contraceptive options, especially LARC methods and increased contraceptive counseling. Concerns about the impact of hormonal contraception on breastfeeding, specifically DMPA, are persistent and prevalent.

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EVENTS ASSOCIATED WITH NEXPLANON INSERTION AND REMOVAL: INTERIM RESULTS FROM THE NEXPLANON OBSERVATIONAL RISK ASSESSMENT STUDY (NORA)

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Objectives: We aimed to characterize the frequency of insertion- and removal-related events among Nexplanon users in the US during standard clinical practice.
Methods: This large, prospective, noninterventional cohort study follows 7369 new users of Nexplanon who were recruited by health care professionals in the US between December 2011 and March 2014. Questionnaires are completed by patients at 6-month intervals (beginning on the day of insertion and ending 6 months after implant removal) and by providers who insert or remove the implant. Data analysis characterizes the frequency of procedure-related events. Follow-up is ongoing.
Results: During 7369 insertions, providers reported 208 events involving 189 patients (2.6% of the study population). Difficulty removing the protection cap was the most common event (93 insertions). A total of 49 patients (0.7%) reported an event at insertion. The most common event was pins/needles/numbness in the arm/hand/fingers (17 patients; 2.3 per 1000 insertions; 95% CI, 1.3–3.7), which was significantly more likely among repeat or consecutive implant users (10.1 per 1000 insertions; 95% CI, 4.6–19.0) than first-time implant users (1.2 per 1000 insertions; 95% CI, 0.5–2.4). Follow-up data through January 2016 show that 271 patients reported 394 events in the implant arm (36.8 per 1000 insertions; 95% CI, 32.6–41.3): pins/needles/numbness (145), severe pain (120), altered strength (47) and other events (82). Of 1413 removal procedures, 16 (1.1%) involved one or more challenges: encasement in fibrotic tissue (7), multiple removal attempts needed (5), local migration (1), deep implant (1) and other challenges (3).
Conclusions: Procedure-related events associated with Nexplanon use are rare.

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LEVONORGESTREL INTRAUTERINE DEVICE EXPULSION AMONG PATIENTS WITH ABNORMAL UTERINE BLEEDING

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Objectives: This study aims to identify factors associated with levonorgestrel intrauterine device (LNG-IUD) expulsion among patients with abnormal uterine bleeding.
Methods: Patients with LNG-IUD inserted for the management of abnormal uterine bleeding between January 2009 and December 2010 were identified. Demographic characteristics, timing of LNG-IUD insertion in relation to the menstrual cycle, uterine cavity length and presence of uterine pathology were evaluated.
The association between patient characteristics and the risk of expulsion was evaluated. A multivariable logistic regression model was created to estimate the likelihood of expulsion based on cavity length and timing of insertion.
Results: Of the 179 patients, expulsion occurred among 39 patients (22%). Uterine cavity length (p=.02), insertion during the first week of the menstrual cycle (p=.01) and endometriosis (p=.03) were associated with an increase in LNG-IUD expulsion. No expulsions occurred among the 17 patients who had IUDs placed in the operating room (p=.01).