



C-Gyn 3

Intrauterine contraceptive devices and infection

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) endorses the views of the International Planned Parenthood Federation (IPPF) that the intrauterine contraceptive device (IUCD) is an effective and safe method of contraception for properly screened women. The IPPF has published a detailed statement about the use of IUCDs, which is a useful resource.

The most widely used devices are the copper containing CuT380A and Multiload Cu 375, while the progestagen-releasing intrauterine system (Mirena) is an alternative which may be used to treat menorrhagia in addition to its high contraceptive efficacy.

A careful history and examination is essential to identify any relative or absolute contraindications to the use of an Intrauterine Contraceptive Device (IUCD). Sexually transmitted infection (STI) risk should be assessed and where appropriate testing for chlamydia trachomatis, neisseria gonorrhoea and bacterial vaginosis be considered prior to insertion or change of an IUCD. Ideally these results should be available prior to IUCD insertion.

All patients should be counselled about the effectiveness and failure rates of IUCDs and their possible short and long-term complications, including menstrual changes and pelvic infection. Both oral and written information should be provided. At the time of insertion of an IUCD any possibility of pregnancy should be excluded.

World Health Organization (WHO) studies have demonstrated a small risk of pelvic infection in the first 20 days after insertion, often relating to asymptomatic and unrecognised STIs. Following this period of increased risk the rate of Pelvic Inflammatory Disease (PID) in IUCD users is approximately the same as would be expected in the general population not using IUCDs.

The balance of evidence suggests that the use of an IUCD does not affect return to fertility in nulliparous or multiparous women.

Women at increased risk of STI acquisition should be counselled about other methods of contraception - WHO recommends that the risks generally outweigh the benefits in women at increased risk of STI's. This risk clearly relates to the sexual relationship/s of the woman and her partner/s but is greater on a population basis for women younger than 25 years of age. FFPRHC (Faculty of Family Planning and Reproductive Health Care RCOG) states that women at increased risk of STI's after counseling may still choose an IUCD and safe sex and condom use should be promoted.

Patients should be advised to attend for review 4 to 6 weeks after insertion of the IUCD and thereafter at least every 1-2 years. They should also be advised to present if abnormal bleeding, or symptoms suggestive of infection or pregnancy occur, or if they are unable to locate the string of the device.

Pap smears in asymptomatic women are performed every two years in Australia and every three years in New Zealand. Cytological examination may reveal Actinomyces-like organisms

(ALOs). It is important to be aware that some ALOs reported in Pap smears are not in fact Actinomyces or are Actinomyces species which do not commonly cause sepsis. Furthermore the presence of ALOs in a Pap smear does not correlate well with culture for Actinomyces nor with the risk of subsequent PID. Certainly the presence of ALOs in the Pap smear of a woman who is asymptomatic should not alone be considered an indication for removal of the IUCD.

Recommendations for management vary. A suggested course of action would be to take a cervical swab for specific formal culture of Actinomyces, which may require a specialized laboratory, special media and/or prior notification of the laboratory. IUCD use may continue provided the culture is negative and the woman asymptomatic. Identification of Actinomyces israelii on culture, or direct immuno-fluorescence if available, should always indicate removal of an IUCD; if the patient is symptomatic prolonged anti-microbial treatment should be used in consultation with a clinical microbiologist or infectious diseases physician; surgery may need to be considered to drain any associated collections.

If pregnancy is diagnosed with an IUCD in situ, the device should be removed if possible because of the risk of serious complications. These complications include a 50% incidence of spontaneous miscarriage and an increased incidence of placental problems such as antepartum haemorrhage, threatened premature labour and adherent placenta.

References

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