



Letter to the editor

The challenge to solve the expulsion problem of immediate postplacental insertion of IUD

Dear Editor,

We have read with interest the article by Cohen et al. entitled “Twelve-month contraceptive continuation and repeat pregnancy among young mothers choosing post-delivery contraceptive implants or postplacental intrauterine devices” [1].

What strikes us time and time again in articles published on postplacental/postpartum insertion of IUDs is the unacceptable high total expulsion as well as the high displacement rates reported [2].

As expressed by the authors, immediate postpartum intrauterine device (IUD) insertion deserves great attention as it can provide immediate contraception and prevents repeat unintended pregnancies. Immediate post placental insertion (within 10 min of delivery of the placenta) of copper-bearing or hormone-releasing IUDs is safe and acceptable. When compared with interval insertion, it however carries a significantly higher risk of full and/or partial expulsions, thus affecting effectiveness and overall patient acceptance. To address this important challenge, an anchoring technique for use in the immediate postplacental period was developed in Belgium in the 1980s and has been the subject of extensive clinical research since 1985 at the University in Ghent and in internationally conducted clinical trials [3]. The results of these trials indicated that the anchoring technology was a valid concept and can use copper or LNG as the contraceptive agent. Since that time, the technology has passed through several phases of redesign and improvement.

Recently, the technique was optimized to allow for suspension of the frameless IUD for intraoperative cesarean implantation of the anchor. A historical review was published by Wildemeersch et al. [4]. The technique consists of the precise placement of the non-biodegradable anchoring knot immediately below the serosa of the uterus, followed by fixing the knot in place with an absorbable suture. This adaptation of the frameless anchoring technology has shown to be easy, quick and safe in pilot trials with no expulsions at 12 months. It was readily apparent that the technique could

be considered a major advance, suitable for general use after C-section delivery due to its simplicity requiring limited training. The position of the anchor, in the fundus of the uterus can also be identified using sonography by localizing the stainless steel marker attached to the anchoring knot.

We prefer the frameless implantable IUD (GyneFix[®]) over framed IUDs as the latter may cause discrepancy with the uterine cavity and displacement and embedment during involution of the uterus, particularly during prolonged lactation as hyper involution in these women is not uncommon [5]. Uterine compatibility will dictate patient continuation rates and overall patient acceptance. In addition, the availability of adequate contraception immediately post Cesarean delivery may have an added benefit in reducing the number of Cesarean sections performed worldwide. By allowing for adequate timing between pregnancies full uterine recover would be achieved thus allowing women to achieve vaginal delivery. Studies have shown that 40 to 80% of women can successfully achieve vaginal births after Cesarean section (VBAC) [6]. This may aid in curbing the high Cesarean birth rates seen in many countries. Further studies should be initiated as it appears that the suspension technology is the only solution to solve the expulsion problem associated with postplacental insertion of IUDs. They will also expand the method as a strategy to reduce unintended pregnancy and rapid repeat pregnancy in adolescents.

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