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Improving Pain Management During Intrauterine Device Insertion

Announcer:
You're listening to *Advances in Women's Health* on ReachMD. Here's your host, Dr. Alexandria May.

Dr. May:
This is *Advances in Women's Health* on ReachMD, and I'm Dr. Alexandria May. Here with me to talk about current approaches to pain management for intrauterine device, or IUD, insertion, is Dr. Mitchell Creinin. He's a Distinguished Professor and the Director of the Complex Family Planning Fellowship at UC Davis Health Medical Center in Sacramento. Dr. Creinin, welcome to the program.

Dr. Creinin:
Thank you for inviting me.

Dr. May:
Starting with a high-level overview, Dr. Creinin, why is pain management during IUD placement so important? And how can it influence the overall patient experience?

Dr. Creinin:
In my many decades of practice, it's interesting how pain management was not something that was commonly discussed by clinicians. And I think the ability of patients to get on social media and talk about it has really brought it more to the forefront. And it's unfortunate. For years—many, many years—I have always talked about it with my patients, because it's a real issue.

When I go over it with patients now, I bring up the idea that if you had your teeth extracted—a wisdom tooth extraction—without local anesthetic, you would think that dentist is a horrible person. And for many years, I think clinicians talked down the amount of pain that it can cause, especially for people that have never had a vaginal delivery.

I found years ago that giving local anesthetic in the cervix and talking with patients up front has made a big difference in not only their acceptance of these measures to help them through this, but also their realization that just by talking about it, I understand that this is something that they may go through.

I have patients now who come to me even just for removal, and they're scared of that because of the trauma from their placement. And it doesn't have to be this way. We have these tools, and providing adequate pain management, both in discussing it up front and then providing that care and understanding for patients, can greatly increase satisfaction by the patient trust, and I think have a big influence on their uptake of long-acting intrauterine contraception.

Dr. May:
Well, let's build off of that and take a look at some guidelines. The Centers for Disease Control and Prevention emphasize that a person-centered plan for IUD placement and pain management should be made based on patient preference. The American College of Obstetricians and Gynecologists also recommend a shared decision-making approach when discussing options. So with those guidelines in mind, how can proactive patient-specific planning help address gaps in care?

Dr. Creinin:
I think that these guidelines bring to the forefront the need for clinicians to talk about pain as part of the process and how we can help each patient. It gets away from these outdated assumptions that IUDs shouldn't hurt, or that pain isn't even worth addressing. I wonder sometimes if clinicians think that if they talk about the pain, that patients will change their mind. I think social media has brought it so much to the forefront that we have to move past that and realize that patients will find the clinicians who are open and who have

respectful conversations with the patient, and that patients will feel more autonomous and be more likely to accept an IUD or to go through the process.

This brings to mind a patient I had recently who told me that she was so traumatized by her prior IUD placement that she was just afraid to go through anything, and wanted to go to the operating room, even just to have a removal.

Dr. May:
For those just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Alexandria May, and I'm speaking with Dr. Mitchell Creinin about strategies for improving pain management during IUD insertion.

So Dr. Creinin, now that we have some background on the importance of pain management, I'd like to talk about some specific options that are available. How do tools like paracervical blocks or nitrous oxide work in mitigating pain? And how have you implemented them in your practice?

Dr. Creinin:
Well, I find the guidance—I want to go back to that for a second—really interesting, because both the CDC and ACOG guidance has mentioned different things we can do, but there's really clear data on what helps and doesn't help.

Nonsteroidal analgesics make absolutely no difference if they're taken in advance. When you look at pain studies, it's important to understand that you have to look at both statistical significance and clinical significance, and every single pain study that's done with nonsteroidal analgesics show that it doesn't reach any level of clinical difference in pain. It doesn't mean that patients can't take it afterwards for cramping or any pain they have while they're at home, but taking it in advance doesn't mitigate any pain that they have during the insertion process.

Using misoprostol in any way, shape, or form that you want to give it to try to soften the cervix and make the pain less makes absolutely no difference in more than four double-blind, placebo-controlled studies; all it does is cause some cramping in and of itself. That is a waste of time, money, and effort. Nobody should be using nonsteroidal analgesics or misoprostol with the idea that it's going to decrease pain.

Nitrous oxide is another one. That has a prospective randomized trial showing absolutely no benefit. So if you have nitrous oxide in your office for other reasons, great for you, but it will not help with the pain with IUD placement.

The one method that has been shown repeatedly to make a huge difference is placement of a paracervical block. There are providers who think that the paracervical block causes as much pain as the IUD placement, and try to talk their patients out of it. The studies show repeatedly that pain is less with paracervical block use and patients are more satisfied with paracervical block use, primarily in those patients who are vaginally nulliparous, and regardless of the IUD type.

Dr. May:
As a follow-up to that, what kind of response have you seen from patients when these options are introduced?

Dr. Creinin:
For the patient who has never had an IUD before, they very commonly have read about pain with IUD placement. And I just bring that up. I say that you may have seen this information online or on social media, and I want to talk about it. For patients that have had an IUD placement before, this is often new to them—just bringing it up in advance—and they usually feel so relieved and are very thankful that it's something I want to address with them, so that their fears are being handled prospectively. And as a provider, I think they think that I'm a more caring clinician.

I had a patient once tell me that after her last IUD placement, she was in terrible pain, and the nurse just came up to her afterwards because the doctor had left the room and said, "This will be good training for childbirth." That's not how we should be addressing pain with IUD placement.

So I think offering these choices empower patients and can reduce a lot of the fear they have. I also offer patients anxiolytics, if they want, telling them it's not going to help with your pain, but if you are anxious about the procedure, and you can have someone drive you, this is a very worthwhile thing that will reduce the anxiety about having it placed—but again, not the pain.

And what's really interesting to me is I have patients who are nulliparous who say, "I appreciate you've talked to me about this. I want to hold off on the paracervical block, but if I feel that I need it, you can then give it to me." I have patients who say they want the kitchen sink, everything I can do, and we have patients who say, "I don't want the anxiolytic," or "I do," or whatever. But giving them the choice and empowering them, I think, makes a huge difference in the whole process.

Dr. May:

That's amazing, and I'm loving this conversation.

Let's shift gears for a moment and talk about the financial side of this issue, especially since comfort options sometimes aren't covered by insurance. How do you approach conversations around cost? And what reactions do you see from patients when out-of-pocket expenses come into play?

Dr. Creinin:
Can you imagine going to a dentist and the dentist telling you, "I'm going to pull your wisdom teeth, but I'm not going to use local anesthetic unless you pay me more." I mean, that's inherent to the process, to the procedure. We should be looking at it that way.

Local anesthesia is incredibly cheap. In fact, I know at our institution, the bottle of local anesthesia is cheaper than the bottle of sterile water. That's the equivalent size. It's very cheap. We all have this equipment in our office to provide paracervical blocks. There's no reason cost should be part of it.

There are codes—the billing codes—that can be used for applying paracervical block. Some get paid and some don't. I look at it as if I get paid, that's a bonus. But there's no reason that I should be putting a patient through a procedure in which a local anesthetic is indicated, or that she should be allowed to choose it, where I have to say that, "Well, your insurance may or may not pay for it, and I want to charge you more." That, again, should be inherent to the procedure.

And I think being transparent and respectful in discussing the fact that there is no cost issue, right, or not even bringing it up, is important. I don't care if it's covered. I will put the billing code in for my paracervical block. And if it's not covered, then so be it. But the patient deserves something that will help her through that pain.

Dr. May:
Absolutely. Before we wrap up our program, Dr. Creinin, do you have any final thoughts you'd like to leave with our audience?

Dr. Creinin:
I think for providers that have ultrasound in the office, something I found is a very useful tool is using ultrasound guidance during placement. One of my fellows, a couple years back, did a study where we looked at not sounding for IUD placement because we were watching with an ultrasound in the office, and we used our medical assistants to do the ultrasound. So it wasn't like we did something where you needed two doctors. And interestingly, we found that the peak level of pain wasn't any different, which I think tells us that that first time you go into the uterus, whether it be with a sound or the IUD, you get that same pain. But the procedure was able to be significantly shorter.

And I also find now that we're doing this in clinical practice routinely, based on this study, is that it distracts the patients, because they can watch on the ultrasound as well, and so you don't need to sound because you can see where the IUD is going. You can see that it's in the middle of the cavity or at the top of the cavity, depending on which IUD you're using.

So that's a little trick, but I think all of these tools to bring into play and discuss with the patient makes an environment for the patient to feel like we are really taking care of her. And I know that we focus a lot on the pain in vaginally nulliparous patients, because it makes a huge bit of difference. And there are

studies that suggest that for patients who've had a vaginal delivery that the pain is not improved significantly. But it doesn't mean that they're not doing that reading online, just like the other patients. So I talk about it with those patients and also tell them, "You've had three vaginal deliveries, I don't think this is going to make a huge difference, but if you feel you need it, I'm happy to give it to you."

So I think that we need to be those proactive people to help our patients feel more comfortable about the whole process.

Dr. May:
That's a great comment for us to think on as we come to the end of today's program. And I want to thank my guest, Dr. Mitchell Creinin, for joining me to discuss pain management strategies for IUD insertion and how they're being implemented in real-world practice. Dr. Creinin, it was great having you on the program.

Dr. Creinin:
Thank you for having me.

Announcer:
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