

Editorials

Optimal Use of IUDs: Why Aren't We There Yet?

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In this issue of *American Family Physician*, Hardeman and Weiss discuss the importance of educating physicians on the safety and effectiveness of intrauterine devices (IUDs).¹ With unintended pregnancies exceeding one-half of all pregnancies,² long-acting, reversible contraceptives are a critical choice for many women.³ From 2002 to 2009, the use of these contraceptives increased nearly fourfold among women of all ages (from 2.4% to 8.5%), and increased 15-fold among adolescents 15 to 19 years of age (from 0.3% to 4.5%).³ Supportive clinical settings and physician education could maximize IUD use.

Although the IUD is an attractive choice for many women, multiple barriers within a clinical setting can hinder more widespread use. One challenge for physicians is guidance on selecting appropriate IUD candidates. Evidence supports IUDs for nulliparous women and adolescents, but IUD use in these patients has lagged because of educational barriers and physician and patient attitudes.⁴ In one study of New York City-area clinics, adolescent patients were least likely to receive information on IUDs compared with other, more user-dependent methods.⁴

Inconsistent policy statements add to the confusion.⁴ The American Academy of Pediatrics supports IUD use in multiparous adolescents who take precautions against sexually transmitted infections, whereas the American College of Obstetricians and Gynecologists encourages IUD use in adolescents regardless of parity.^{5,6}

Although physicians are generally highly focused on helping adolescents prevent unplanned pregnancy, some have negative perceptions about IUDs stemming from early versions, such as the Dalkon Shield. In addition to unfounded concerns about infertility and ectopic pregnancy, some physicians may be concerned that IUDs might decrease the use of condoms, increasing the risk of sexually transmitted infections.⁴ Greater focus on physician education is needed to bridge the gap between the expanding number of candidates for long-acting, reversible contraceptives and acceptance in clinical settings that these methods are a safe option.

Despite the benefits of IUDs, procedural risks exist. For example, there is an increased risk of uterine perforation if an IUD is inserted in the postpartum period or during

lactational amenorrhea. One study shows that the risk of perforation during the first six months postpartum is 11 to 13 times higher than the risk after six months postpartum. However, the overall risk of uterine perforation is low, at 2.2 per 1,000 IUD insertions.⁷ The decision to minimize the time between delivery and IUD insertion should be accompanied by physician understanding of the increased risks involved and by informed consent.

The high up-front cost of an IUD (average cost is \$800 for the device and \$180 for insertion) results in many patients opting for alternatives that seem less expensive. However, the cost of an IUD is comparable to the total annual cost of the contraceptive pill, patch, and ring. Recent legislative developments may provide some relief to this hurdle. The Affordable Care Act classifies contraception as a recommended preventive service that is covered by insurance with zero-dollar cost sharing. The Affordable Care Act should also decrease lapses in coverage. Unfortunately, many women have little contact with the health care system between pregnancies despite having insurance, so a more proactive consultation by the physician before delivery may help inform a patient about her contraceptive options after delivery.

IUDs are safe and effective. Physicians with an understanding of IUD procedures and of their benefits and risks are more likely to appropriately counsel their patients.

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