Intrauterine contraception in general practice

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IN these disquieting days when reports of adverse effects of the contraceptive pill (Inman and Vessey 1968) are receiving wide publicity more and more women are reluctant to use, and an increasing number of doctors are chary about prescribing, this method of family planning. This paper describes the use of the intrauterine contraceptive device (IUCD) in general practice.

Selection of cases

Parous women requesting advice on contraception were offered the IUCD. Nulliparae are more difficult to fit and experience more side effects (Frampton and Matthews 1967). Despite many requests only three nulliparae were fitted.

Interview

A history is taken and the patient warned of the side effects and the small risk of pregnancy. It is stressed that expulsion may occur and the patient is advised to check pads before disposal and to examine herself after menstruation. The action of the device is explained in terms of tubal hurry, leading to failure of implantation of an immature zygote (Bengtsson and Moavab 1966, Margulies 1964).

Equipment required

1. Couch and good source of light
2. Bivalve speculum
3. IUCD and introducer (manufactured by Ortho)
4. Uterine sound (manufactured by Ortho)
5. Forceps for handling IUCD
6. Volsellum forceps
7. Sponge holding forceps
8. Receiver and swabs

Metal instruments are sterilized by boiling; the IUCDs and introducers by immersion in 1:2000 hibitane.

Fitting

This is well described (Frampton 1967, Frampton and Matthews 1967, Frith 1966, Mills 1965) but has required modification in general practice.

In the presence of a chaperone the patient is examined in the dorsal position to exclude pregnancy or pelvic disease. After swabbing the cervix with hibitane the size and direction of the uterine cavity is defined with a sound which slightly dilates the os. Using sterile forceps the device is loaded into its introducer which is then guided through the cervical canal until its flange rests on the cervix. The plunger is depressed extruding the device into the uterus. It may be necessary to steady the cervix with a volsellum but this is avoided whenever possible. The vagina is re-examined to exclude forniceal tenderness which may indicate the rare possibility of uterine perforation.

Twenty minutes are allowed per patient of which 15 are spent at interview.

The patient re-attends after three months when the device is checked and advice given on symptoms.

Results

In 30 months since November 1966, 200 patients have attended the IUCD clinic:

134 were NHS patients and 66 were referred by other doctors. One hundred and ninety-eight devices have been in use for a total of 160 woman years.

Age. All ages from 17 to 47 were represented (figure 1). The drop in numbers after the age of 32 also occurs in oral contraceptive users (Inman and Vessey 1968). Older women appear reluctant to change to modern methods of contraception.

Figure 1

Age distribution of 200 patients attending for fitting of IUCD

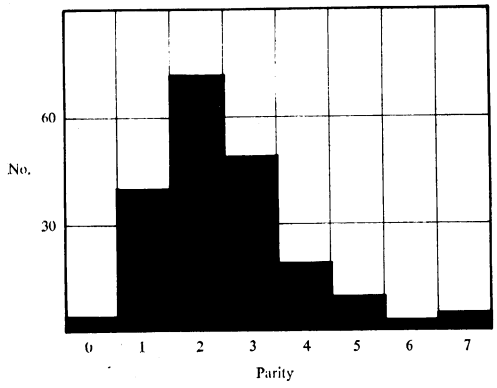

Figure 2

Parity of 200 patients attending for fitting

Parity. Figure 2 shows parity figures which include abortions. Despite warnings of a higher risk of symptoms three nulliparae were anxious to try an IUCD; none experienced symptoms which suggest a relation to motivation. One patient with renal tuberculosis who had a miscarriage and been advised against further pregnancy tolerated the device well.

Time of fitting. Patients were fitted at any time during the cycle. If there was doubt about pregnancy the patient was asked to return after her next period.

Type of device at primary fitting. The devices are described elsewhere (Frampton 1967, Frith 1966).

At first only Margulies Spirals were available. These were difficult to get into the introducer and protrusion of the rigid tail through the cervix caused husbands to complain. Later the Lippes Loop supplanted the use of spirals.

Five small and 11 standard spirals were fitted. Lippes Loop 'A' was used in the patient who had had one pregnancy ending in abortion and Lippes Loop 'B' was used in nulliparae. Loop 'C' was fitted to the remainder except in three cases, fitted with 'D' when Loop 'C' was temporarily unavailable.

Difficulty in fitting. Twenty-six patients, of whom 16 were in the first 60 cases fitted, gave rise to difficulty and two required fitting by a consultant.

In 18 cases the patient's nervousness led to spasm of the internal os. Acute retroversion or anteversion and buckling of the introducer caused difficulty in three and two cases respectively. Three patients complained of pain and three fainted after fitting.

Anxiety is reduced by reassurance and the presence of another woman. In some, sublingual glyceryl trinitrate reduced cervical spasm. Pain was relieved by codeine and fainting reduced by keeping the patient flat for a few minutes after fitting.

Pregnancy. There were two uterine and no ectopic pregnancies (Ramkissoon-Chen and Kong Ta-Ko 1966) giving an incidence of 1.25 pregnancies per hundred woman years (HWY).

The incidence of pregnancy for Lippes Loop 'D' is 2.9 ± 0.3 (Tietze 1966) and for Lippes Loop 'C' 2.4 per HWY (Frith 1966). Thus four pregnancies are expected in this

series. The low incidence may be due to stressing at interview the patient's responsibility for checking her device.

Pregnancy may occur because the loop has been expelled, because it has perforated the uterus or, rarely, when it is correctly placed in utero. In this series one pregnancy occurred through expulsion and one when it remained in the uterus throughout pregnancy.

It has been suggested that, as the patient's responsibility is diminished with this method, termination should be available in case of failure. Each case should be considered on its own merit but if the risk of pregnancy has been explained to and accepted by patients then, in my view, there is no indication for termination.

Salpingitis. There were two cases. One patient developed a tubo-ovarian abscess diagnosed at laparotomy for suspected ectopic pregnancy. The second was diagnosed clinically and settled with rest and antibiotics. One patient refused to have her loop removed, the other parted with it reluctantly.

Pelvic inflammation associated with Lippes Loop 'D' occurs in 2.1 ± 0.2 per HWY (Tietze 1966) though Mills (1967) in a series of 10.2 HWY reports only one probable case. Jackson (1965) states that bleeding and infection requiring hospital admission occur in less than one per cent.

The association between IUCD and infection is difficult to define. Willson (1962) showed that the device does not provide a ladder for ascending infection and Mills (1967) suggests that the device may exacerbate pre-existing subclinical infection.

Symptoms following fitting. Of 198 patients fitted 155 have attended for follow up. Sixty-six patients complained of one or more symptoms (table I). Apart from the two cases of salpingitis bleeding was the most troublesome side effect. Twenty-five per cent noticed heavier periods but in only seven per cent was it sufficient to warrant treatment, with removal of the device in 1.5 per cent. Most cases responded to oral iron and ascorbic acid 200 mg t.i.d. More refractory bleeding was controlled by the pill for two or three cycles after which it rarely recurred. Thus patient tolerance is good and one is impressed by the appreciation expressed of the method by most users (Mills 1967).

TABLE I

Symptom	*Number*	*Removals*
Heavy periods insufficient to warrant treatment	36	0
Heavy periods warranting treatment ..	14	3
Mittelblutung	9	0
Discharge	5	0
Menstrual irregularity	4	0
Slight dysmenorrhoea..	4	0
Severe pain (due to salpingitis)	2	1
Backache	2	0
Occasional dyspareunia	2	0
Amenorrhoea (negative anti-HCG)	1	1
Cure of dysmenorrhoea	1	0

Expulsion. Seventeen devices were expelled: 14 were Lippes Loop 'C', two small spirals and one a Lippes Loop 'B'. Five patients expelled more than one device: two finally retained Lippes Loop 'D', two were fitted with Saf-T-Coils and one decided on further pregnancy.

Removal. Apart from symptomatic indications five IUCDs were removed because the patient wanted a further pregnancy.

Postnatal fitting. Forty-two patients (21 per cent) were fitted between six and 20 weeks after delivery but before menstruation recommenced. In each case fitting was

easy though one patient fainted. The incidence of symptoms requiring treatment was 1:21 compared with 1:13 for the remaining patients. Thirty-five per cent of all expelled loops occurred in this group.

Despite a higher expulsion rate and a theoretically greater risk of perforation the low incidence of symptoms warrants fitting at the postnatal examination.

Summary

Fitting of IUCDs in general practice is described. Over 30 months, 198 devices have been in use for 160 woman years. There have been two pregnancies and two cases of salpingitis. Other symptoms requiring treatment occurred in 15 patients with removal of five devices, three for heavy bleeding. Postnatal fitting was associated with fewer side effects.

Acknowledgement

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"Airline pilots are subject to regular tests of skill and knowledge throughout their career—I'm sure I wouldn't want to fly with one who wasn't. Many of us 'soloed' in medicine on Tiger Moths yet find ourselves struggling with the therapeutic equivalent of the Boeing 707, with the prospect of a clinical Concorde to come. Don't we owe it to our passengers to institute periodic examinations of competence? . . . Seniority (*pace* the British general practitioner's payments) is not always synonymous with knowledge and skill. Examinations, like hanging, would concentrate the mind wonderfully. ". . . It is a curious paradox that doctors can be rational, objective, yet adventurous too, in research and practice; but so reactionary and Iearful elsewhere. Perhaps fear is the key—fear of being reduced to a sophisticated garage repair business; a dread of being turned on and off with the ease and availability of tap-water. fs that why we cling to those good old phrases and attitudes; nostalgia for the secure Victorian atmosphere they evoke; the halcyon days of autocratic medicine, patrician doctors, and respectful and uncritical patients?

". . . Some years ago I went to a corrida—a pageant at once disgusting and beautiful. We in medicine remind me of the bull. Bemused and irritable—angered by the banderilleras of public opinion—reflexly charging the crippling, lacerating picador of changing morality—inbred rigidity of thought driving us towards the silver death beneath the scarlet muleta of the State matador. I remember one thing from the Plaza del Toros; the bull always loses.

"We had better hurry up and change the odds."