NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Copper intrauterine device contraception (IUD)

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

West of Scotland Sexual Health Managed Clinical Network

NHS Ayrshire & Arran | NHS Dumfries & Galloway | NHS Forth Valley | NHS Greater Glasgow and Clyde | NHS Lanarkshire

Adapted from West of Scotland Protocol *Sandyford Guidelines*

COPPER INTRAUTERINE DEVICE CONTRACEPTION GUIDELINE

What's New

This guideline is in keeping with the CoSRH Clinical Guideline: Intrauterine contraception (March 2025)].

fsrh-clinical-guideline-intrauterine-contraception-mar-23-amended.pdf

This guideline does not cover immediate post partum intrauterine contraception (IUC) provision.

Information on the following has been updated: Increased expulsion rates in those with BMI>25

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Abbreviations

IUC intrauterine contraception

IUD intrauterine device

Cu-IUD copper intrauterine device

LNG-IUD levonorgestrel intrauterine device

UKMEC United Kingdom Medical Eligibility Criteria

Other abbreviations have been defined within the body of the document.

Introduction

Cu-IUDs are non-hormonal and vary in size and shape (Table 1). They consist of copper and plastic and may contain barium for radio-opacity. They can be used for regular and emergency contraception (EC),(see Emergency Contraception Protocol), and are effective immediately following insertion.

Main mode of action of a Cu-IUD is inhibition of fertilisation through the effect of copper on the ovum and sperm. Copper also inhibits the passage of sperm into the upper reproductive tract, and causes an inflammatory response within the endometrium, which could impair implantation.

2. *Efficacy, duration of action and choice of device*

- Cumulative pregnancy rates for Cu-IUDs with 380mm^2 copper are between 0.1 and 1% after the first year of use.
- Pregnancy rates are lowest for T-shaped devices which have a copper surface area of 380 mm^2 with copper banding on both the arms and stem.
- Cu-IUDs with longest duration of use should be used as they reduce the risk of infection, perforation and expulsion associated with reinsertion (see Table 1).
- Contraceptive effectiveness is not affected by use of enzyme-inducing drugs or weight/BMI
- The intrauterine ball is not available in the UK at the time of guideline publication

If a Cu-IUD with a copper surface area ≥300 mm^2 is inserted in those ≥40 years old, the CoSRH supports extended use of the device, and the Cu-IUD can be used for contraception until menopause. It can be removed 1 year after the final menstrual period if this occurs after age 50 years.

Table 1: Types of copper intrauterine devices listed in the British National Formulary*Checked 11/9/25
(reproduced from https://www.fsrh.org/documents/ceuguidanceintrauterinecontraception/)

Device	Copper content (mm^2)	Uterine length (cm)	Licensed use duration (years)	Frame size (W x L) (mm)	Loading tube width (mm)
Framed, banded copper arms					
Copper T380 A®	380	6.5–9	10	31.9 x 35.9	4.75
T-Safe® 380A QL	380	6.5–9	10	31.9 x 35.9	4.75
T-Safe® 380 A	380	6.6–9	10	31.9 x 35.9	4.5
TT 380® Slimline	380	≥7	10	31.6 x 36.2	4.75
Flexi-T®+ 380	380	≥6	5	28 x 32	3.5
Mini TT380® Slimline	380	5–7	5	23.2 x 29.5	4.75
Framed, copper in stem only					
Nova-T® 380	380	6.5–9	5	32 x 32	3.6
UT380 Standard®	380	6.5–9	5	32 x 32	3.8
Neo-Safe® T380	380	6.5–9	5	31.9 x 31.8	3.7
Novaplus T 380® Cu	380	6.5–9	5	32 x 32	3.6
Novaplus T 380® Cu 'mini'	380	'Mini' size = 5	5	32 x 28.4	3.6
UT380 Short®	380	≥5	5	32 x 27	3.8
Multiload® Cu375	375	6–9	5	19.5 x 32.5	3.6
Multi-Safe® 375	375	6–9	5	19.5 x 34.8	3.6
Ancora® 375 Cu	375	≥6.5	5	20 x 35	3.8
Load® 375	375	≥7	5	19.5 x 32.5	3.6
Flexi-T® 300	300	6.6–9	5	28 x 32	3.5
Frameless					
GyneFix® 330 **GyneFix® 200**	330 200	Suitable for all uterine sizes	5	2.2 x 30	4.75
Silver IUD					
Novaplus T380® Ag	380	'Normal' size = 6.5–9 'Mini' size = 5	5	32 x 32	3.6

- L, length; IUD, intrauterine device; W, width.

3. Assessing Suitability

Few medical conditions contraindicate use of IUC (see UKMEC)
UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) | CoSRH

The use of the Cu-IUD is contraindicated if there is a known or suspected allergy or hypersensitivity to any of the components of the device.

4. Cu-IUD use in specific patient groups

i. Young People, individuals who have never been pregnant and individuals who have never been sexually active can use a Cu-IUD.

ii. Transgender and gender-diverse individuals assigned female at birth (TGD-AFB).
The medical indications and contraindication are the same as for cis-gender women. The Cu-IUD may appeal to TGD-AFB individuals who wish to avoid hormones. Genital examination pre-insertion, pelvic cramping or bleeding may exacerbate gender dysphoria. Testosterone therapy can cause vaginal atrophy and dryness, which may add to the physical discomfort of examination- consider pre-procedure treatment with local vaginal estrogen for 2 weeks prior to IUD insertion.

iii. After Pregnancy
When inserted within 48 hours of childbirth, clinicians need to be appropriately trained in this technique which is different from standard.

If >48 hours have passed, insertion should be delayed until 28 days after childbirth (UKMEC3).

After medical abortion, or medical or expectant management of miscarriage, Cu-IUD can be inserted any time after expulsion of the pregnancy, providing there is no clinical suspicion of sepsis and no new risk of pregnancy. In early medical discharge (products passed at home), ensure there is no ongoing pregnancy prior to insertion with low sensitivity pregnancy testing no sooner than 3 weeks post abortion.

A Cu-IUD can be inserted immediately after surgical abortion or surgical management of miscarriage or ectopic pregnancy, providing there is no clinical suspicion of sepsis.

iv. After gestational trophoblastic disease (GTD)
A Cu-IUD should not be inserted until human chorionic gonadotropin (hCG) levels are normal.

v. Peri-menopause:

Examination and endometrial assessment should be considered prior Cu-IUD insertion for perimenopausal individuals who have heavy and/or erratic bleeding or a recent change in bleeding pattern. Requirement for investigation should follow local guidelines.

vi. Breast Cancer

There are no contraindications Cu-IUD use with current or previous breast cancer (UKMEC1)

vii. Individuals with raised BMI

Insertion may be more challenging in terms of assessment of uterine position and gaining access to the uterus. Practical considerations include having a range of speculum sizes, appropriate weight limit examination couch and large blood pressure cuff. There is an increased risk of expulsion in those with BMI>25

viii. Individuals at Risk of Infection

A sexual history should be taken prior to Cu-IUD and screening offered to those at risk of STIs.

Increased risk of STIs, no recent contact of gonorrhoea (GC) or Chlamydia (CT) and asymptomatic – IUD can be inserted without prophylactic antibiotic treatment - UKMEC 2

Current pelvic inflammatory disease (PID), postpartum or post-abortion sepsis, known GC infection, symptomatic CT infection, and purulent cervicitis are all contraindications to Cu-IUD insertion (UKMEC4).

Individuals who have symptoms of possible STI and/or PID or are asymptomatic but are a current or recent contact of GC or CT, should ideally delay IUD insertion until test results are available, and until symptoms have resolved. Offer a bridging contraceptive method.

Following a positive CT or GC result, an IUD can be inserted once antibiotic treatment is completed, any test of cure requirements performed, and they are asymptomatic.

Treatment for confirmed or suspected CT, GC or PID; please see relevant specific guidance

If emergency IUD insertion cannot be delayed:

- Known asymptomatic CT or GC infection: consider insertion on the same day that treatment is commenced – discuss with senior clinician.
- Current or recent partner is known to have GC or CT infection - consider antibiotic prophylaxis if asymptomatic.
- Symptomatic of possible CT or GC but test results not available - consider antibiotic prophylaxis

IUD insertion should be delayed until known *Mycoplasma genitalium* has been adequately treated and symptoms have resolved.

Other infections

There is no indication to screen for other lower genital tract organisms in asymptomatic individuals considering IUC.

Bacterial vaginosis, Trichomonas vaginalis or Candida diagnosed or suspected - these should be treated but the Cu-IUD can be inserted without delay.

Group B Streptococcus – no need to treat or delay Cu-IUD insertion.

Group A streptococcus (GAS) is a rare but serious infection that should be treated urgently. Cu-IUD insertion should be delayed until treatment is complete.

ix. Discuss with a senior clinician if:

- **Uterine cavity distortion**
- **Previous endometrial ablation**
- **Under follow up for gestational trophoblastic disease**
- **Immunosuppression/ taking immunosuppressants including patients with adrenal insufficiency and / or taking corticosteroids**
- **History of postural orthostatic tachycardia syndrome (PoTS)**
- **Known to have inherited bleeding disorders**
- **Anticoagulants**
- **Cardiac disease**
- **Wilson's Disease**

5. Health Risks associated with Cu-IUD use

There are no health risks associated with Cu-IUD use

6. Side effects

Inform potential Cu-IUD users about possible bleeding pattern changes, such as heavier, longer or more painful menses, or intermenstrual bleeding.

7. Cu-IUD insertion

i. Discussion

This is essential to ensure individuals make an informed choice about their contraception options and can give informed consent. These may be undertaken face-to-face, via telephone or virtual appointment, or by self-assessment and signposting to patient resources. Women can be encouraged to watch an eight minute information film produced by Lothian Sexual Health available at https://www.lothiansexualhealth.scot/contraception/iud-ius/

ii. When can a Cu-IUD be inserted

A Cu-IUD can be inserted at any time during the menstrual cycle providing that pregnancy can be reasonably excluded (see Box 1). Recommendations for starting or switching to a Cu-IUD can be found in Table 2 and Table 3.

The Cu-IUD can be used for EC if inserted within 5 days of the first episode of UPSI that cycle, or within 5 days of the earliest expected date of ovulation (see emergency contraception protocol)
Contraception After Pregnancy | CoSRH

Box 1: Critieria for reasonably excluding pregnancy

Healthcare practitioners can be ***reasonably certain*** that an individual is ***not currently pregnant*** if any one or more of the following criteria are met ***and*** there are no symptoms or signs of pregnancy:

- They have not had intercourse since the start of their last normal (natural) menstrual period, since childbirth, abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
- They have been correctly and consistently using a reliable method of contraception. (For the purposes of being reasonably certain that an individual is not currently pregnant, barrier methods of contraception can be considered reliable providing that they have been used consistently and correctly for every episode of intercourse.)
- They are within the first 5 days of the onset of a normal (natural) menstrual period. They are less than 21 days postpartum (non-breastfeeding individuals).*
- They are fully breastfeeding, amenorrhoeic ***and*** less than 6 months' postpartum.*
- They are within the first 5 days after abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
- They have not had intercourse for >21 days ***and*** have a negative high-sensitivity urine pregnancy test (able to detect human chorionic gonadotrophin (hCG) levels around 20 mIU/ml).

*See UKMEC 2016[2] and FSRH Guideline Contraception after Pregnancy[103] for recommendations regarding use of combined hormonal contraception after childbirth.

Table 2: Starting Cu-IUD (no recent hormonal contraception) [from CoSRH Clinical Guideline: Intrauterine contraception (March 2023)]

Current Situation	Timing of insertion of LNG-IUD	Additional Precautions required
No recent hormonal contraception and no recent pregnancy	Any time in a natural menstrual cycle if reasonably certain the individual is not pregnant* or at risk of pregnancy (unless qualifies for pregnancy use as EC)	No
Cu-IUD within licensed duration of use	Any time	Ideally abstain/use condoms for 7 days prior to change in case new device cannot be inserted unless criteria for EC insertion are met
Cu-IUD past licensed duration of use	Any time in a natural menstrual if reasonably certain the individual is not pregnant* or at risk of pregnancy (unless qualifies for use as EC)	No
Post partum (vaginal birth or Caesarian section, breastfeeding or non-breast feeding)	Within 48 hours after childbirth or from 4 weeks after childbirth if it is reasonably certain the individual is not pregnant* or at risk of pregnancy (unless criteria for use as EC apply)	No
Following abortion of miscarriage	Post-surgical abortion or surgical management of miscarriage: ideally insert at the time of the procedure Post-medical abortion or miscarriage: IUC can be inserted any time after expulsion of pregnancy	No
Following use of oral emergency contraception	Within the first 5 days (120 hours) following first UPSI in a natural menstrual cycle or within 5 days after the earliest estimated day of ovulation	No additional precautions required
	If there has been UPSI in this natural menstrual cycle that occurred >5 days ago AND it is >5 days after the earliest estimated date of ovulation (or date of ovulation cannot be estimated), a Cu-IUD cannot be inserted until pregnancy can be excluded by a high-sensitivity pregnancy test taken ≥21 days after last UPSI	Condoms or bridging contraception until Cu-IUD can be inserted

UPSI (unprotected sexual intercourse)
*See Box 1 for how to exclude pregnancy.

Table 3: Switching to Cu-IUD from a hormonal contraceptive method

Current Situation	Timing of insertion	Additional Precautions required
CHC use	At any time if CHC has been used correctly (or criteria for use as EC are met)	No
POP (traditional, desogestrel or drospirenone	At any time if POP has been used correctly (or criteria for use as EC are met)	No
ENG implant within 3 years after insertion	Any time	No
ENG implant in situ for 3-4 years	Any time if PT negative	No Repeat PT 21days after last UPSI
ENG implant in situ for >4 years and no UPSI in the last 21 days	Any time if PT negative	No
ENG implant in situ for >4 years and UPSI in the last 21 days	If PT negative AND all UPSI that has taken place in the last 21 days was within the last 5 days, Cu-IUD can be inserted as EC	No
	Cu-IUD cannot be inserted if any UPSI occurred between 5 and 21 days ago	Consider PT and EC. Bridge with alternative contraception until pregnancy can be excluded by a high sensitivity PT taken ≥21 days after last UPSI

Table 3: Switching to Cu-IUD from a hormonal contraceptive method (contd)

Current Situation	Timing of insertion	Additional Precautions required
Progestogen-only injectable (DMPA) ≤14 weeks post-injection	Any time	No
Progestogen-only injectable (DMPA) >14 weeks post-injection and no UPSI since 14 weeks	Any time	No
Progestogen-only injectable (DMPA) >14 weeks post-injection AND UPSI since 14 weeks post-injection, all of which took place ≥21 days ago	Any time if PT negative	No
Progestogen-only injectable (DMPA) >14 weeks post-injection AND UPSI since 14 weeks post-injection, some of which took place within the last 21 day	If PT negative AND all UPSI that has taken place in the last 21 days was within the last 5 days, Cu-IUD can be inserted as EC	No
	Cu-IUD cannot be inserted if any UPSI occurred between 5 and 21 days ago	Consider PT and EC. Bridge with alternative contraception until pregnancy can be excluded by a high-sensitivity PT taken ≥21 days after last UPSI

Table 3: Switching to Cu-IUD from a hormonal contraceptive method (contd)

Current Situation	Timing of insertion	Additional Precautions required
52 mg LNG-IUD in situ for < 8 years OR 19.5 mg LNG-IUD in situ for < 5 yrs OR 13.5 mg LNG-IUD in situ for < 3 yrs	Any time	No Ideally abstain/use condoms for 7 days prior to change in case new device can't be inserted
52 mg LNG-IUD in situ for >8 yrs and no UPSI within the last 21 days OR 19.5 mg LNG-IUD in situ for >5 yrs and no UPSI within the last 21 days OR 13.5 mg LNG-IUD in situ for >3 yrs and no UPSI within the last 21 days	Any time if PT negative on day of replacement	No
52 mg LNG-IUD in situ for >8 years† and UPSI within the last 21 days OR 19.5 mg LNG-IUD in situ for >5 years and UPSI within the last 21 days OR 13.5 mg LNG-IUD in situ for >3 years and UPSI within the last 21 days	If PT negative AND all UPSI that has taken place in the last 21 days was within the last 5 days, Cu-IUD can be inserted as EC	No

CHC, combined hormonal contraception; DMPA, depot medroxyprogesterone acetate; DRSP, drospirenone; ENG, etonogestrel; HFI, hormone-free interval; IUC, intrauterine contraception; LNG-IUD, levonorgestrel intrauterine device; POP, progestogen-only pill; PT, pregnancy test; UPSI, unprotected sexual intercourse. †Recommendations for the 52 mg LNG-IUD insertion relate to devices inserted before age 45 years.

iii. Insertion checklist

x. Intrauterine contraception pre-insertion checklist for the minimum criteria that should be met prior to insertion.

The clinician inserting the intrauterine contraception (IUC) should ensure that (as a minimum) the following criteria are met prior to insertion:

- ☐ Individual assessed as medically eligible
- ☐ Checked there are no indications for IUC to be inserted in an alternative setting/service
- ☐ Checked there are no allergies to IUC content or local anaesthetic
- ☐ Checked it is a suitable time to insert and any requirement for additional contraception/follow-up pregnancy testing
- ☐ Considered and offered sexually transmitted infection (STI) testing and/or cervical screening as appropriate
- ☐ Individual advised about:
- ☐ Different IUC types available
- ☐ Contraceptive effectiveness and time to effect (including need for additional contraception and/or follow-up pregnancy test)
- ☐ Duration of use (for contraception and other indications)
- ☐ Potential bleeding patterns
- ☐ Other potential side effects and risks
- ☐ Insertion procedure and associated risks including: pain, infection, expulsion, perforation, failure, ectopic pregnancy, non-visible threads
- ☐ Analgesia options and option to stop at any time during the procedure
- ☐ Signs/symptoms that require review
- ☐ How and when to check threads
- ☐ Removal procedure
- ☐ Individual given opportunity to ask questions and to reflect on new information and return for procedure or alternative at another time if they wish
- ☐ Type of IUC device confirmed with patient and assistant
- ☐ Expiry date on IUC and analgesia checked
- ☐ Suitably trained assistant present
- ☐ Appropriate equipment available (e.g. resuscitation equipment, appropriate examination couch/lighting, range of speculum sizes, analgesia options)

iv. Safe Cu-IUD Insertion

Training: Clinicians offering Cu-IUD insertion should hold the COSRH Letter of Competence in Intrauterine Techniques. Immediate postpartum intrauterine contraception (PPIUC) technique is different to standard Cu-IUD insertion and should only be performed by those who have trained in this technique.

Assistants and Chaperones: A chaperone should be offered for all intimate examinations. The chaperone's role is to support the patient. An appropriately trained assistant should be present during all cervical instrumentation procedures. The assistant can also fill the role of a chaperone if trained. The assistant should support the individual during the Cu-IUD procedure and monitor the patient for any signs of pain or distress.

Check the device has not expired: If an expired device is inadvertently inserted, inform the individual of the error and offer the option of retaining the device or having it removed and replaced. The expiry date relates to the microbiological sterility of the device. Risk of infection from loss of microbiological sterility could well be lower than the risk of infection if the device is replaced again. Manage the error according to local clinical governance policies.

v. Pain associated with Cu-IUD insertion

Cu-IUD insertions can cause mild-to-moderate pain or discomfort. Analgesia options should be discussed, offered and documented. NSAIDs such as ibuprofen can reduce pain after Cu-IUD insertion.

8. Emergency management for problems at IUD insertion

Cu-IUD insertion can trigger a vasovagal response. Drugs and equipment required for resuscitation must be available, accessible, clearly labelled, adequately maintained and their location known to all staff. Follow locally agreed risk management policies for the treatment of emergencies.

9. Documentation

Clinicians inserting or removing Cu-IUDs should document the procedure and consultation in line with local policy and protocol and notify (where applicable and with consent) other relevant healthcare providers (e.g. primary care) of the type of device, date of insertion and recommended duration of use.

10. Aftercare advice and follow-up

After Cu-IUD insertion, individuals should be given information on the device inserted, including the name of the device, its mode of action, duration of use and that it will become effective immediately. The manufacturer's booklet/card will usually be given to the patient.

Where a Cu-IUD has been inserted outside of product licence information about how and when to perform a pregnancy test should be given.

With the exception of PPIUC, routine post-insertion check-ups with a clinician are not required. They should be advised to seek review at any time if they have concerns or cannot locate the coil threads. They should be given information on who to contact and how. Local pathways should be followed for PPIUC insertions and follow-up.

Cu-IUD users should feel for the threads within the first 4–6 weeks after insertion and then at regular intervals (e.g. monthly or after menses) and if they have any concerns suggestive of Cu-IUD displacement (e.g. change in bleeding pattern, new-onset pelvic pain). Clinicians should explain how to feel for Cu-IUD threads and that users should seek review if threads are not palpable, thread length becomes shorter or longer, or the stem of the device is felt. The individual should be advised to abstain or use an alternative method of contraception until the Cu-IUD position is confirmed, and if there has been any recent, condomless sex they should seek advice as emergency contraception may be required.

Individuals should be advised to seek urgent review if they have:

- Symptoms of pelvic infection (e.g. change in vaginal discharge, pelvic pain and intermenstrual/ postcoital bleeding)
- Concerns regarding their bleeding pattern
- A positive pregnancy test.

Women can be encouraged to watch a 4 minute video produced by The West of Scotland Managed Clinical Network for Sexual Health for women who have recently had a Cu-IUD inserted which gives advice on what to expect, how to check for threads and when to seek advice.
https://sexualhealthdg.co.uk/iuc.php

11. Advice about use of menstrual cups, discs and tampons

There could be increased risk of expulsion associated with menstrual cup use. Users should be advised to follow the manufacturer's instructions. Care should be taken not to dislodge the Cu-IUD by accidently pulling the Cu-IUD threads when removing the menstrual device'

There are not robust studies to inform effect of use of tampons on risk of expulsion.

There is no clear evidence of increased risk of infection associated with use of tampons, menstrual cups/discs or intercourse in the days or weeks after Cu-IUD insertion.

12. Advice for individuals requiring magnetic resonance imaging

Individuals should inform their MRI department so that local guidelines can be followed. Cu-IUD inserted outside of the UK may contain different metals (eg Chinese ring contains steel) and might not be MRI safe. Advice should be sought from the local radiology department.

13. Managing problems associated with IUC

i. Bleeding

Give information about expected bleeding patterns as they can change with Cu-IUD use. Although unscheduled bleeding may be caused by the Cu-IUD itself, other causes (e.g. pregnancy, infection, pathology) should be considered and investigated in line with CoSRH Clinical Guideline: Problematic Bleeding with Hormonal Contraception.

Options for HMB include:
Tranexamic acid, NSAIDs or a 3-month trial of COC or switch to LNG-IUD (if medically eligible).

ii. New Onset Pelvic Pain

This should be assessed, and pregnancy excluded. Causes may or may not be related to the Cu-IUD. A clinical history and physical examination will identify the differential diagnoses and guide the investigation and management. Where alternative causes have been excluded and the individual wishes Cu-IUD removal and replacement, clinicians could consider offering replacement with an alternative device (e.g. switching to a device with a smaller or different-shaped frame). There is, however, insufficient evidence to suggest one particular device over another.

Table Three: Possible causes if new onset pelvic pain [from CoSRH Clinical Guideline: Intrauterine contraception (March 2023)]

Gynaecological causes	Other causes
IUC malposition/partial expulsion/expulsion	Appendicitis (± sepsis)
IUC perforation	Diverticulitis (± sepsis)
Pregnancy (ectopic, miscarriage, labour)	Irritable bowel syndrome/constipation
Pelvic inflammatory disease (± abscess/sepsis)	GI infection (± sepsis)
Ovarian cyst accident	GI obstruction/perforation/necrosis
	Urinary tract infection/pyelonephritis (± sepsis)
	Hernia

iii. Pregnancy

The risk of any pregnancy, including ectopic pregnancy, during use of Cu-IUD and after insertion of a Cu-IUD for EC is very low. However, among pregnancies that occur with a Cu-IUD in situ, the proportion that is ectopic is greater than among pregnancies occurring without IUD in situ.

A previous ectopic pregnancy is not a contraindication to use of Cu-IUD.

Cu-IUD in situ and a positive pregnancy test: follow local assessment pathways.

Pregnancy less than 12 weeks gestation and threads visible: removal may improve pregnancy outcome
Pregnancy after 12 weeks gestation: refer to obstetric team

iv. Infection

The risk of PID appears to increase in the first 3 weeks after Cu-IUD insertion but overall, the risk is very low (<1% of all IUD users). Instrumentation of the uterus can lead to ascending infection and PID.

If symptoms are suggestive of PID manage as per PID guideline (see guideline, insert link)

In mild-to-moderate cases, the Cu-IUD can remain in situ if there is improvement over the following 2-3 days. If not, recommend removing the Cu-IUD, considering pregnancy risk from the previous 7 days. Discuss alternative contraception, the need for EC and follow-up pregnancy testing. Delay further IUD insertion until antibiotic treatment has been completed and all signs and symptoms have resolved.

Candida & Bacterial vaginosis (BV): symptomatic, recurrent, confirmed VVC/BV not controlled by standard management may require switch to an alternative method of contraception.

Actinomycosis and presence of actinomyces-like organisms (ALO): Incidental findings of ALO are rare now that liquid-based cytology (LBC) and/or primary human papillomavirus (HPV) testing are used for cervical screening.

v. Malposition

If malposition is suspected clinically or detected on a scan refer to senior clinician
Advise use of an alternative method of contraception meantime.

vi. Perforation

Overall risk of approximately 1–2 per 1000, greater if breastfeeding and postpartum at the time of insertion.

If identified at the time of insertion: Stop procedure: remove Cu-IUD; monitor blood pressure and pulse rate and level of discomfort until stable. Consider broad-spectrum antibiotics to reduce the risk of peritonitis. Offer alternative contraception and advise to seek review if significant pain or signs/symptoms of infection develop.

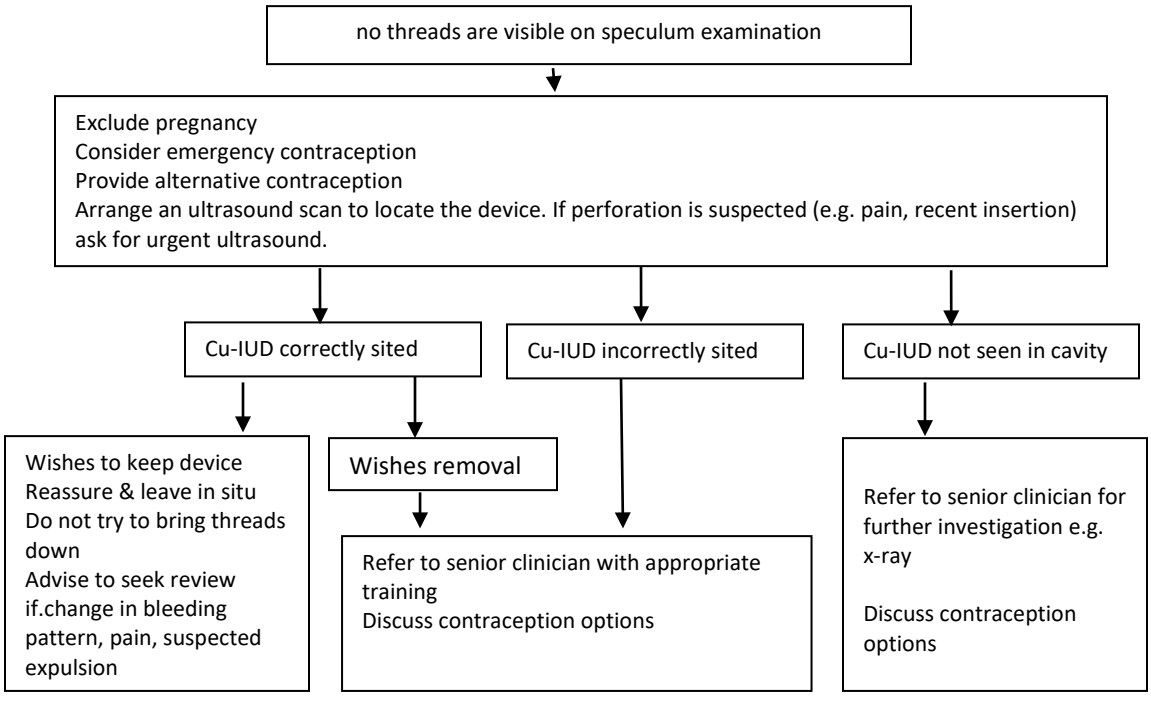
Delayed identification of perforation. Lower abdominal pain, non-visible threads or changes in bleeding could indicate uterine perforation but are non- specific.

Arrange urgent USS to locate the device. If not seen on scan, arrange a plain abdominal and pelvic X-ray. In the interim, consider EC, and offer alternative contraception.

Morbidity associated with detection and removal of an intraabdominal Cu-IUD is low but uterine perforation can involve damage to the abdominal or pelvic viscera, bladder or bowel. If confirmed perforation, refer to gynaecology.

Wait at least 6 weeks after a known or suspected uterine perforation before inserting a subsequent IUD. Refer to service with available ultrasound.

vii. Non-visible threads



viii. Expulsion

The overall risk is approximately 1 in 20 and appears to be most common in the first year of use, particularly within 3 months of insertion

Expulsion rates are higher

- in immediate postpartum insertion compared with interval postpartum insertion

- in adolescents
- insertion after late first-trimester or second-trimester surgical abortions,
- in individuals with fibroids and HMB
- with use of a menstrual cup
- those who have had a previous expulsion
- those with a BMI >25

There is no evidence to suggest that switching to a different IUD may reduce the risk of a further expulsion. If there have been ≥2 IUD expulsions, a pelvic ultrasound to assess the uterine cavity may be helpful prior to insertion of a further IUD. Post-insertion USS is not predictive of the likelihood of further expulsion but can provide immediate confirmation of correct positioning.

14. IUD removal

i. Facilitating Safe Removal

There is no formal CoSRH training for IUD removal: follow local pathways for developing and maintaining competence. CoSRH resources to support clinicians removing IUC:

CoSRH Bitesize: Intrauterine contraception (IUC) removal | CoSRH

- E-lfh eSRH Module 15, Section 10 “Removal of IUC”.

Clinicians removing Cu-IUDs should be:

- Able to discuss ongoing contraception needs and provide this or signpost to another provider.
- Able to provide preconception counselling or signpost to another provider.
- Able to recognise pregnancy risk and the need for Emergency Contraception
- Competent at speculum examination
- Able to recognise an abnormal cervix and know how to refer for further examination.
- Aware of how to manage non-routine findings (e.g. non-visible threads).

ii. Timing of Cu-IUD removal or replacement

- Those who do not wish to become pregnant should be advised to avoid UPSI for 7 days prior to Cu-IUD removal.
- Avoid UPSI for 7 days prior to Cu-IUD removal and replacement in case it is not possible to insert the new device.

Table5: Cu-IUD removal [from CoSRH Clinical Guideline: Intrauterine contraception (March 2023)]

Situation	Advice
Removal for a planned pregnancy	• Offer preconception advice • Cu-IUD can be removed at any time • User should be advised that pregnancy is possible as soon as IUC removed

Removal – not for planned pregnancy and not switching to an alternative	• Abstain/use condoms in the 7 days prior to removal • If there has been UPSI in the 7 days prior to removal, ideally defer Cu-IUD removal until no UPSI for 7 days • Where this is not possible, consider EC AND Recommend a PT 21 days after the last episode of UPSI
Removal – menopause	• Contraception is no longer required > 55 yrs or >50 years and LMP >12 months ago • Cu-IUD should normally be removed when it is no longer required and not left in situ indefinitely
Removal and replacement	*See section* When can a Cu-IUD be inserted
Removal – switching to an alternative method of contraception	See CoSRH Guidance Switching or Starting Methods of Contraception

iii. Unexpected findings at IUC removal

On removal of a Cu-IUD check the device is intact and that it is the expected device and the correct information about duration of use/follow-up/ongoing contraception has been given.

For advice with regards to broken or /incomplete device refer to CoSRH Clinical Guideline: Intrauterine contraception (March 2023)
https://www.fsrh.org/standards-and-guidance/documents/ceuguidanceintrauterinecontraception

iv. Removal of an unusual device

For advice with regards to Cu-IUDs inserted abroad where the clinician is not familiar with the device refer to CoSRH Clinical Guideline: Intrauterine contraception (March 2023)
https://www.fsrh.org/standards-and-guidance/documents/ceuguidanceintrauterinecontraception

v. Difficult removals:

Difficult Cu-IUD removals may be due factors such as anatomical variations, Cu-IUD malposition (including perforation), clinician experience and/or the level of pain or discomfort experienced. When there is difficulty in removing a Cu-IUD, a referral should be made to an experienced provider.

References

CoSRH Clinical Guideline: Intrauterine contraception (March 2023)

fsrh-clinical-guideline-intrauterine-contraception-mar-23-amended.pdf **(accessed 11/9/25)**