# Best practices for reducing pain associated with intrauterine device placement

*Adapted from:*

Bayer LL, Ahuja S, Allen RH, Gold MA, Levine JP, Ngo LL, Mody S. Best practices for reducing pain associated with intrauterine device placement. Am J Obstet Gynecol. 2025;232(5): 409–21. doi: 10.1016/j.ajog.2025.01.039.

Intended for healthcare professionals only
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# Why is there a need for guidance on best practices for reducing IUD placement pain?

- While most IUD placements are easy and may be associated with no to mild pain, pain can be severe, particularly for nulliparous women[1,2]
- Pain and fear of pain related to IUD placement represent notable barriers to IUD uptake[3]
- Anxiety and anticipatory pain may lead women to feel a higher level of pain[4]

- No current standard of care has been established specifically to manage pain with IUD placement, resulting in wide variation in clinical practice. The recent Bayer et al. article[5] aims to provide practical, evidence-based, and expert-informed guidelines for managing pain during IUD placement
- By reducing anxiety and pain, this guidance aims to make IUD placement a more positive experience for women

IUD: intrauterine device.

1. Gemzell-Danielsson K, et al. Fertil Steril. 2012;97(3):616-22.e1-3; 2. Donders G, et al. Eur J Contracept Reprod Health Care. 2023;28(1):1–9; 3. Bracken J, Graham CA. Eur J Contracept Reprod Health Care. 2014;19(4):276–84; 4. Akdemir Y, Karadeniz M. Eur J Contracept Reprod Health Care. 2019;24(3):240–5; 5. Bayer LL, et al. Am J Obstet Gynecol. 2025;232(5):409–21.

# Overall recommendations for training, service philosophy, counselling, and language

## Overarching principles

Patients should be respected, empowered, and well informed, taking charge of their health through shared decision-making. Care should be personalized and tailored to each individual's experiences, accounting for any past traumas and ensuring triggering language is avoided. This requires a trained and competent team from first to last contact.

## Staff training and service

An optimally trained team can improve the patient's journey by reducing misinformation, error, anxiety, and pain, as well as instilling trust and confidence. Common misinformation that can result in unnecessary delays in IUD placement includes recommendations that the patient must be menstruating or that a separate visit is required for sexually transmitted infection and cervical cancer screening before IUD placement. Administrative staff should provide accurate pre-placement information and resources. Clinical support staff facilitates a smooth process. All staff should use therapeutic language.

## Patient-centered counselling

The patient should have thorough patient-centered counselling before, during, and after the procedure. The procedure should be described and explained in layman's terms with therapeutic language.

## Therapeutic language and verbal analgesia ("verbocaine")

Set expectations in a positive manner ("some patients may experience discomfort, but each experience is different"). Ensure the patient feels in control ("we can stop at any time"). Use a calm tone and therapeutic language ("placement" instead of "insertion"). Use non-triggering language ("let your knees fall out towards the walls").

IUD: intrauterine device.

Bayer LL, et al. Am J Obstet Gynecol. 2025;232(5):409–21.

# Pre-placement: preparing the woman

## Patient-centered counselling

**Before the IUD insertion takes place, counsel the patient on what to expect during the procedure**; this is essential as patients tolerate pain better when they receive effective counselling. Patients should feel empowered, informed, and in control. Analgesia should be discussed and offered to all patients prior to IUD placement. Advise the patient on relaxation techniques such as paced breathing.

## Assess risk factors for pain

**Assess risk factors for potentially more painful procedures:***

- Age (adolescence)
- Nulliparity
- History of trauma
- Multiple cesarean deliveries
- Anxiety or mood disorder
- Not currently breastfeeding
- Baseline anxiety (fear)
- Dysmenorrhea
- Anticipation/expectation of pain
- Anatomical (extreme retroverted uterus, anteflexed/retroflexed uterus, narrow cervical os, tortuous cervical canal, uterine fibroids)
- Previous painful IUD placement
- Prior cone biopsy of cervix
- Previous negative reaction to pelvic exam
- Prior failed IUD placement
- Race†
- Size of IUD inserter‡
- Lack of mental preparation
- Difficulty / pain with uterine sound
- Higher education level (≥7 years)
- Time between last delivery and IUD placement (>13 months)
- Higher emotional reactivity
- Menstruation (nulligravidas)

## Premedication

**Evidence on the efficacy of pre-placement NSAIDs is conflicting, but they may benefit some patients**. If the patient desires same day placement and has no contraindications, NSAIDs may be provided: naproxen 1–2 h prior (Rx 500–550 mg, or 2 OTC = 440 mg) OR Rx ketorolac 20 mg, 1–2 h prior OR Rx ketorolac 30 mg IM, 20 min prior OR OTC ibuprofen 800 mg, 1–2 h prior. Anxiolytics may be given to those with substantial anxiety.

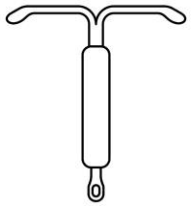
*Currently, it is not possible to predict with certainty whether a patient will experience severe pain or discomfort during the procedure; †due to complex social and institutional realities and inadequately treated pain; ‡ increased pain has been reported with 52 mg LNG-IUD compared with 13.5 mg, 19.5 mg, or copper 380 $mm^2$ IUD. IM: intramuscular; IUD: intrauterine device; LNG: levonorgestrel; NSAID: nonsteroidal anti-inflammatory drug; OTC: over-the-counter.

Bayer LL, et al. Am J Obstet Gynecol. 2025;232(5):409–21.

# Pre-placement: environmental, non-pharmacological, and CIM considerations

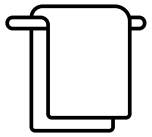
**Warm/heat available for abdomen**

**Low lighting**



**All necessary equipment is on hand**, including speculum, lubricant, IUD, and any additional equipment needed for more difficult placements (e.g., ultrasound or dilators)

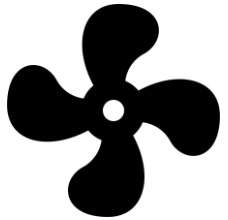
**Reiki**
A Japanese stress reduction and relaxation practice



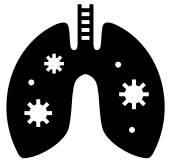
**Cool towels available for forehead**

**Calming, slow, rhythmic music**

**Acupressure**
To Large Intestine-4 or Spleen-6



**Standing rotating fan**
For cooling and audio-tactile distraction



**Breathing techniques**
Teach techniques such as square breathing

**Aromatherapy**

CIM: complementary and integrative medicine; IUD: intrauterine device.

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# During placement: low and high pain risk

## Low risk of pain

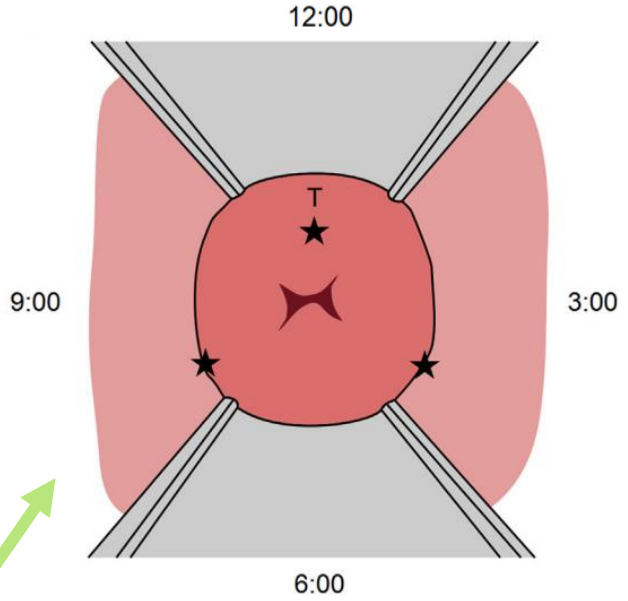
Use topical anesthetic:

- 5 mL EMLA cream (2.5% lidocaine / 2.5% prilocaine) [allow 5–7min for onset]
- 10% lidocaine spray to cervix & canal [allow 3 min for onset]
- 10 mL of 20 mg/mL mepivacaine through a hydrosonography catheter [allow 2 min for onset]*

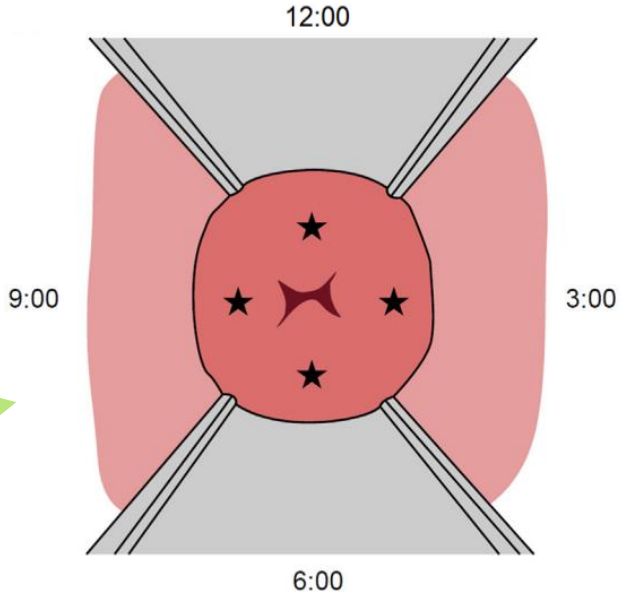
## High risk of pain

Use para- or intracervical block:

- Paracervical block: 18 mL of 1% lidocaine buffered with 2 mL sodium bicarbonate [2 mL of 1%/2% lidocaine applied to tenaculum site, ~9 mL each injected at 4:00 and 8:00]
- Intracervical block: 3.6 mL 2% lidocaine injected at 3:00, 6:00, 9:00, and 12:00




**Paracervical block injection points**




**Intracervical block injection points**

*Note that hydrosonography catheters may not be widely available in clinics where IUD placements occur. Alternatives may include an 18-gauge angiocatheter or 3 mm Novak curette. EMLA: eutectic mixture of local anesthetics; IUD: intrauterine device.

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# During placement: substantial anxiety or failed first insertion

## Substantial anxiety

- Use anxiolytics (allow sufficient time to take effect and ensure patients have transportation home)
- Consider placement under moderate sedation or anesthesia

## Failed first insertion

- Misoprostol, 400 mcg buccally or vaginally 3–4 h pre-placement
- Ultrasound-guided placement
- Consider placement under moderate sedation or anesthesia

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# Post-placement

**Recovery:** Allow patient to lay flat for 5 min before gradually raising the head of the table to avoid vasovagal reaction. Offer beverage or snack and heating pad.

**Acupressure techniques:** Provide acupressure on Large Intestine-4 or Spleen-6 to reduce cramping.

**Medication:** Advise patient to take PO naproxen (440–450 mg every 12 h) or PO ibuprofen (600–800 mg every 6–8 h) with food for the first 24 h post-procedure.

**Post-placement counselling:** Review what to expect post-procedure.

PO: per os (oral).

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# Recent ACOG clinical consensus guidance (1/2)

**ACOG has recently published a Clinical Consensus on pain management for in-office uterine and cervical procedures, including IUD placement. Their IUD consensus is:**

**There is a need to improve pain management**

- While IUDs are highly effective, patients may experience pain during placement, and this can reduce IUD uptake
- Patient acceptance of IUDs can be improved by addressing anticipated pain and providing adequate pain management during insertion
- Every patient having an IUD placed should receive thorough counselling about the potential for pain associated with this procedure and should be provided with options to mitigate potential pain

**Evidence supports the use of local anesthetics but not pre-placement NSAIDs**

- There is high heterogeneity in studies assessing IUD placement pain
- However, overall, a series of systematic reviews support the use of local anesthetic agents, specifically lidocaine (as paracervical block or by genital mucosa application), for management of pain associated with IUD insertion over other interventions such as misoprostol
- Data using cervical-ripening agents to ease IUD insertion pain are conflicting; although useful in some individuals with a history of unsuccessful placements, they may increase pain or be associated with adverse events with misoprostol use
- Evidence increasingly suggests NSAIDs are ineffective in managing pain at the time of IUD placement but may reduce post-procedural pain

ACOG: American College of Obstetricians and Gynecologists; IUD: intrauterine device; NSAID: nonsteroidal anti-inflammatory drug.

Pain Management for In-Office Uterine and Cervical Procedures: ACOG Clinical Consensus No. 9. Obstet Gynecol. 2025;146(1):161–77.

# Recent ACOG clinical consensus guidance (2/2)

**ACOG has recently published a Clinical Consensus on pain management for in-office uterine and cervical procedures, including IUD placement. Their IUD consensus is:**

**For many interventions, more evidence is required to draw firm conclusions**

- There is insufficient evidence to recommend the use of inhaled nitrous oxide for pain management during IUD placement
- Evidence on the efficacy of pre-procedural administration of anxiolytics for pain management during IUD insertion remains lacking
- Additional research is needed to evaluate the risks and benefits associated with providing intravenous sedation for IUD insertion, including accessibility and cost effectiveness
- Evidence for ultrasound-guided placement is lacking; however, this has shown efficacy in reducing pain compared with blind IUD insertion. Noted overall limitations to ultrasound guidance include needing access to ultrasound equipment and a knowledgeable ultrasound assistant
- Further research into non-pharmacologic pain interventions, including interventions to reduce anxiety, is needed

**Overall, ACOG concludes that local anesthetic agents may reduce pain associated with IUD placement**

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