Managing Pain Associated with Intrauterine Device (IUD) placement

Click here to continue to the summary and interactive menu to explore the information you requested.

The information presented here is summarized from Best Practices for Reducing Pain Associated With Intrauterine Device Placement published by Bayer L, et al., in 2025.

Bayer Healthcare recommends use of its IUDs in appropriate patients in accordance with the Prescribing Information: Kyleena®; Mirena®, and Skyla®.

For healthcare professionals only.

Background

Intrauterine devices (IUDs) are highly effective, long-acting, reversible contraceptives

Pain and anxiety over anticipated pain during placement remains a barrier to IUD use, which is compounded by:

- Emphasis of negative experiences on social media
- No established standards of care to address pain with IUD placement
- Underestimating patient pain, leading to undertreatment

In 2024, the Centers for Disease Control and Prevention released updated guidance in the US Selected Practice Recommendations (SPR) for contraceptive use

- The need to counsel on pain and have a pain management plan was emphasize; however, no clear algorithm was developed

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Development of Pain Management Guidance

In March 2024, Bayer Medical Affairs conducted a virtual advisory board with the goal of bringing together a group of expert physicians to **develop practical, evidence-based, expert informed guidance on managing pain during IUD placement.**

Following the advisory board, the group developed recommendations and guidance for IUD placement pain management.

WHO DEVELOPED THE GUIDANCE?

- OB/GYNs (6)
- Adolescent medicine subspecialists (2)
- Family medicine physician (1)

All had extensive experience with IUD placement and an interest in pain management, including:

- Complex family planning training (4)
- Clinical LARC trainers (4)
- Contributor or member of IUD guidelines (2)
- Published on pain during IUD placement (4)

HOW WAS THE GUIDANCE DEVEOPED?

Published evidence from RCTs, reviews, and meta-analyses were included → If unavailable, comparison data from related GYN procedures considered → Where evidence was lacking, of low quality, or contradictory, expert recommendations were made based on clinical experience

GYN, gynecologic; IUD, intrauterine device; LARC, long-acting reversible contraceptives; RCT, randomized controlled trial.

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Overarching Principles and Staff Training

Recommendations to Optimize IUD Placement Comfort

CLICK EACH IMAGE TO LEARN MORE

Patient-centered

Optimally trained team

Trauma-informed care

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IUD, intrauterine device.

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Overarching Principles and Staff Training

Patient-Centered

Patient should feel empowered, informed and in control, with the ability to pause, stop, or reschedule at any time during the placement procedure and an alternative contraceptive provided, if desired

permission

empowerment

CHOICE

Valuing individual experiences

Personalized care

Team approach

Trauma-informed care

RESPECT

Informed consent

Shared decision-making

Patient autonomy

Click back to menu of overarching principles

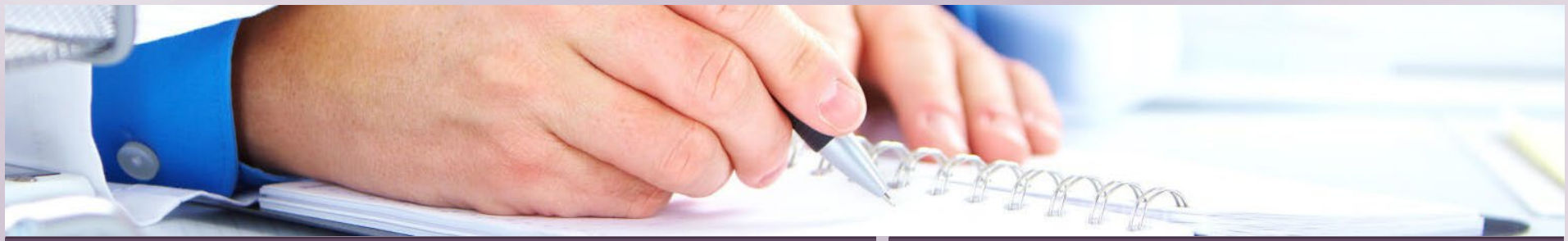
Click to learn about optimally trained team

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Overarching Principles and Staff Training

Optimally Trained Team

An optimally trained team can improve the patient journey by reducing misinformation, error, anxiety, and pain



Scheduling and reception considerations

Scheduling IUD Placement

- In most cases, counseling, consent, and placement can occur in one visit
- Schedule placement **anytime** during menstrual cycle
- Separate visit is **NOT** required for STI and/or cervical cancer screening
- Schedule sufficient time for counseling, consent, procedure, and aftercare

Pre-appointment considerations

- Patient may eat and drink before appointment
- Encourage appropriate clothing and premedication (NSAID)
- Provide pre-visit patient resources
- Utilize empowering, therapeutic language

Clinical support staff

Trained in aspects of procedure, including

- Use of therapeutic language, and informing patient of their role in supporting their head
- Preparation of equipment
- Monitoring of and ordering supplies
- Facilitating a smooth process
- Providing support during the procedure
- Being aware of impending vasovagal episode, and knowing how to proceed

IUD, intrauterine device; NSAID, nonsteroidal anti-inflammatory drug; STI, sexually transmitted infection.

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Click back to patient centered

Click to learn about trauma-informed care

Overarching Principles and Staff Training

Trauma-Informed Care

Principles of TIC should be applied to all encounters, with universal screening prior to any IUD procedure

What is trauma-informed care?

- TIC suggests that exposure to abuse, neglect, discrimination, violence, or other adverse experiences increases a person's lifelong potential for serious health problems and health-risk behaviors
- TIC acknowledges the need to understand a patient's life experiences to deliver effective care, improve engagement, treatment adherence, and health outcomes
- **Administrative and clinical staff should be trained in trauma-informed practices and optimal use of therapeutic language**

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IUD, intrauterine device; TIC, trauma-informed care.

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Counseling and Pain Management Plan

Recommendations to Optimize IUD Placement Comfort

Agree and develop a patient-centered plan for IUD pain management based on individual preferences

CLICK EACH IMAGE TO LEARN MORE

Candid discussion about anticipated pain

Identify risk factors for more painful procedure

Develop a person-centered pain management strategy

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Counseling and Pain Management Plan

Candid Discussion

Develop a patient-centered plan for IUD pain management based on individual preferences

Candid discussion about anticipated pain

- Provide sufficient, accurate, understandable information
- Describe the procedure in layperson's terms
- Offer to show the speculum and the IUD
- Avoid minimizing pain (may lead to feeling of mistrust and betrayal)
- Compare discomfort to something patients are familiar with (menstrual cramps), may use a scale of 0–10
- Patients should be prepared for three sensation points:
  - Application of instrument to stabilize cervix (tenaculum)
  - Sounding of the uterus
  - IUD placement through cervix into uterus

May feel pressure, pulling, nausea, cramping, or nothing

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Counseling and Pain Management Plan

Identify Risk Factors

Develop a patient-centered plan for IUD pain management based on individual preferences

Identify risk factors for more painful procedure[a]

Social, demographic, and psychological factors

- Age (adolescence)
- History of trauma
- Anxiety or mood disorder
- Baseline anxiety (fear)
- Anticipation or expectation of pain
- Previous painful IUD placement
- Previous negative reaction to pelvic exam
- Race[b]
- Lack of mental preparation
- Higher level of education (≥7 years)
- Higher emotional reactivity

Physical and medical factors

- Nulliparity
- Multiple cesarean deliveries
- Not currently breastfeeding
- Dysmenorrhea
- Anatomical (uterine and cervix, fibroids)
- Prior cone biopsy of cervix
- Prior failed IUD placement
- Size of IUD inserter[c]
- Difficulty or pain with uterine sound
- Time between last delivery and IUD placement (>13 months)
- Menstruation (nulligravidas)

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[a]Currently, it is not possible to predict with certainty whether a patient will experience severe pain or discomfort during the procedure. [b]Race as a risk factor is likely due to complex social and institutional realities and inadequately treated pain. [c]Increased pain has been reported with LNG-IUD 52 mg compared with 13.5 mg, 19.5 mg, and copper 380 mm^2 IUD.

IUD, intrauterine device.

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Click back to candid discussion

Click to learn about pain management plan

Counseling and Pain Management Plan

Pain Management Plan

Develop a patient-centered plan for IUD pain management based on individual preferences

Develop a pain and/or anxiety management plan

- Analgesia options discussed and offered to all patients, regardless of IUD placement risk factors
  - NSAIDs, local anesthetics, paracervical block, moderate or deep sedation (as needed)
  - Anxiolytic options (as needed)
- Benefits and risks of available options and alternatives should be addressed, and a holistic pain management strategy should honor individual needs, preferences, and values

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IUD, intrauterine device; NSAID: nonsteroidal anti-inflammatory drug.

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Pre-procedure Preparation

Recommendations to Optimize IUD Placement Comfort

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Optimal environment

Equipment

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IUD, intrauterine device.

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Pre-procedure Preparation

Optimal Environment

Simple strategies

- Low room lighting
- Music: calming, slow, and rhythmic
- Cooling fan
- Warm towels or heated pads placed on lower abdomen or back may reduce cramping (based on dysmenorrhea studies)
- Cold, wet towels on forehead may provide comfort
- Aromatherapy: lavender or peppermint
- Review breathing techniques that can be used during procedure

Click back to pre-procedure menu

Click to learn about equipment

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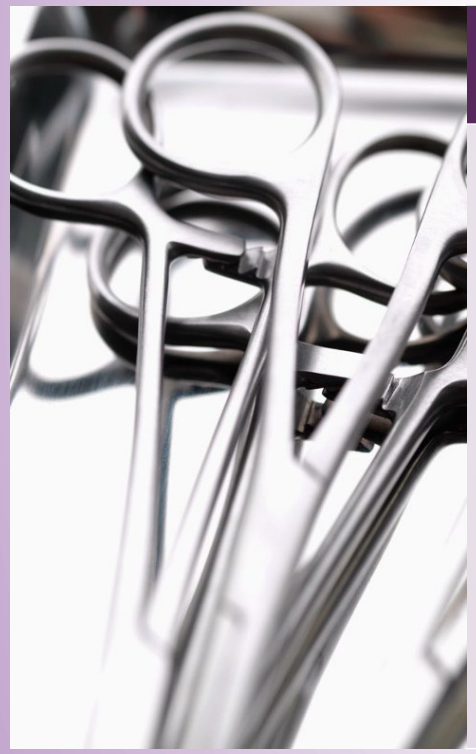
Pre-procedure Preparation

Equipment



Checklist

- Procedure table and supplies[a] checked by the inserting provider (duplicates on hand)
- Correct IUD in stock
- Use draping for privacy
- Appropriately sized speculum and lubricant (both warmed, consider Pederson for nulliparous)
- Uterine sound (plastic, metal, or endometrial biopsy pipelle, maximum of 3 mm in diameter)

Also consider:

- Os finder
- Dilators
- Topical analgesia, and/or equipment for paracervical block (if needed)
- Ultrasound if challenging placement expected

[a]Atraumatic vulsellum or Littlewood forceps showed no difference in pain during IUD placement compared with single-tooth tenaculum.

IUD, intrauterine device.

Bayer L, et al, Am J Obstet Gynecol. 2025; Feb 3 [online ahead of print].

Click back to optimal environment

Click to learn about premedication

Pre-procedure Preparation

Premedication

Analgesics

- Multiple studies have examined use of NSAIDs prior to IUD placement, with variable results
- The expert group recommends:
  - **Naproxen[a]: 500–550 mg (Rx) 1–2 hours prior, or**
  - **Ketorolac**
    - **20 mg oral[a] (Rx) taken 1–2 hours prior; or**
    - **30 mg IM (Rx) given 20 minutes prior; or**
- Additional options include:
  - Naproxen[a] 440 mg taken 1 hour prior, or if unavailable;
  - Ibuprofen[a] 800 mg taken 1 hour prior

[a]Ensure that patient has eaten prior to administration of NSAIDs. Please refer to each product's prescribing information for further information.

IUD, intrauterine device; NSAID, nonsteroidal anti-inflammatory drug.

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During the Procedure

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Word choice and tone

Procedural techniques

Pain management strategies

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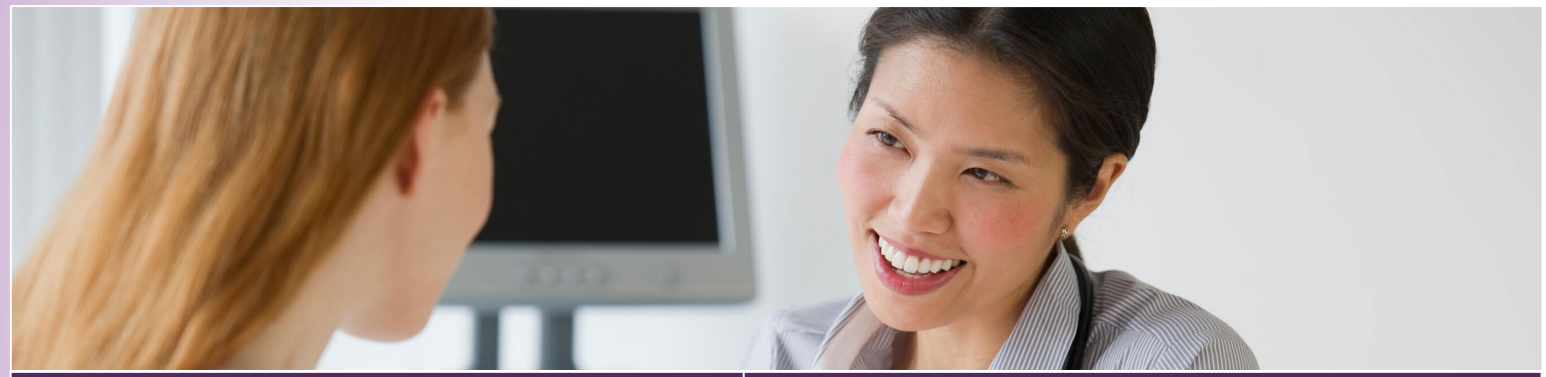
During the Procedure

Word Choice and Tone



Verbal analgesia (“vocal local” or verbocaine)	Word Choice

• Involves **calming, comforting, and distracting patients** throughout the procedure using a *soft, low-pitched voice and speaking slowly*
• May also include casual talk to distract the patient
• Remind the patient that they are in control, and the procedure can be stopped at any time and an alternative contraceptive provided, if desired
	• Avoid medical jargon or negatively loaded language with patients
	  • Use “gentle placement” instead of “insertion”
	  • Use “you may feel a sensation” instead of “a prick/burn/stick”
	• Patients hearing phrases with unpleasant connotations (“you are going to feel a lot of pressure”) reported significantly higher pain scores than those hearing objective phrases (“I am going to introduce the speculum”)

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During the Procedure

Techniques to Reduce Discomfort During Placement

Tenaculum	Gently rock the tenaculum points onto the cervix, time the closure with the patient's exhalation, close the tenaculum one notch only
Dilation	If needed, consider topical local anesthetic or a regional block • Start with an os finder, use smallest possible dilator or sound
Awareness	Verbally check in for discomfort, offer to pause/stop/reschedule
Breathing	Patient can perform paced or rhythmic breathing to help with relaxation
Guided Imagery	"Focus on the clean crinkling of the paper beneath you and the comfortable support of the exam table"
Vasovagal	Use isometric contractions to reduce vasovagal risk

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During the Procedure

Pain Management Strategies Based on Risk Factors

Lower risk of IUD insertion pain

Topical anesthetic

5 mL EMLA cream[a] (2.5% lidocaine/2.5% prilocaine) applied to cervix and cervical canal (5–7 minutes)

10 mL of 20 mg/mL mepivacaine through hydrosonography catheter (2 minutes)

Topical anesthetics require a wait time of 5–10 minutes (depending on type)

Higher risk of IUD insertion pain

(e.g., nulliparous, no prior vaginal delivery)

Buffer: 2 mL sodium bicarbonate
Tenaculum site: 2 mL 1%/2% lidocaine

ICB

3.6 mL 2% lidocaine injected at 3:00, 6:00, 9:00, and 12:00

OR

PCB

18 mL 1% lidocaine: ~9 mL each at 4:00 and 8:00

Specific training on technique is advised, refer if needed

Wait time after PCB or ICB is not required; PCB or ICB involve potential discomfort from the injection

Failed first insertion attempt

Misoprostol

400 mcg buccally or vaginally 3–4 hours prior to placement

Not for routine use

Ultrasound guided

and/or

PCB/ICB

Significant anxiety

Anxiolytics[b]

Prescribed with appropriate precautions

Ensure patient has transportation home, avoids combining with opiates, and informed consent is obtained

OR

Nitrous oxide

Consider IV sedation or placement under anesthesia
(severe anxiety, history of trauma, intellectual disability, complicated anatomy, or patient preference)

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[a]EMLA cream available as generic lidocaine/prilocaine 2.5%/2.5%. [b]Benzodiazepines reduce anxiety, not pain. If prescribed, patient cannot drive afterward and will require a ride home. Simultaneous use of benzodiazepines and opiates may result in respiratory depression, sedation, coma, and/or death. Please refer to each product's prescribing information for further information.

ICB, intracervical block; IUD, intrauterine device; IV, intravenous; PCB, paracervical block.

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After the Procedure

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In the exam room

Post-procedure counseling

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After the Procedure

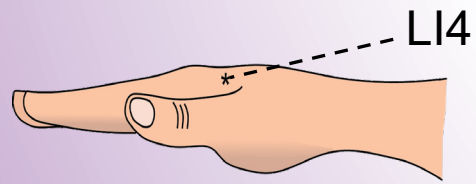
Exam Room

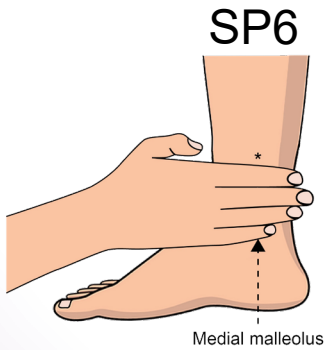
In the exam room

Advise patient to lay supine on table, with legs out of footrests for 5 minutes

Head of table is **gradually** raised
(to reduce vasovagal risk)

Drink/snack can be offered and/or a heating pad for lower abdomen





Acupressure on LI4 or SP6 may be applied bilaterally for a few minutes

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After the Procedure

Post-procedure Counseling

Review what to expect post-procedure and pain management

- Expected levels of pain
- Medication: PO naproxen 440-550 mg every 12 hours; or PO ibuprofen 600-800 mg every 6-8 h with food for first 24 h post-procedure
- Self-care (heating pad, acupressure)
- Cramping, bleeding (and management with pads or tampons)
- Need/duration for use of backup contraception

Leave additional time for patient to debrief about experience and to ask any questions they may have

PO, taken orally.

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Pain Management Guidance

Summary

OVERARCHING PRINCIPLES AND STAFF TRAINING

Applies to all stages of the IUD placement procedure

- Patient should feel empowered, informed, and in control, with the ability to pause, stop, or reschedule at any time during placement procedure and have an alternative contraceptive provided, if desired
- Provider offers personalized, patient-centered, trauma-informed care

Counseling

Pain Management Plan

- Patient-centered candid conversation
- Assess risk factors
- Discuss analgesia options

Pre-procedure

Preparation

- Calming room environment
- Appropriate procedural equipment
- Premedication(s) [ie, NSAID, anxiolytic]

Procedure

Techniques

- Word choice and tone
- Visualization, breathing techniques
- Analgesia administration [eg, topical, PCB]

After the Procedure

Recovery

- Rest, fluids, snack
- Acupressure
- Medication [NSAID]

For an infographic summary of this publication, please click **here.**

IUD: intrauterine device; NSAID: nonsteroidal anti-inflammatory drug; PCB, paracervical block.

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