The Shrewsbury and Telford Hospital NHS Trust

Management of Pregnancy with Coil in Situ

Version 6

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Comments	:	References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version.

For Triennial Review

Version	Implementation Date	History	Ratified By	Full Review Date
1	2008		Gynae Governance	2011
2	24th June 2011	Full review	Gynae Governance	June 2014
3	10th May 2012	Updated in line with national guidance	Gynae Governance	May 2015
4	8th December 2015	Full review Update to location of services	Gynae Governance	December 2018
5	17th July 2019	Full review	Gynae & Fertility Clinical Governance	17th July 2022

6	18th October 2022	Full Review – confirm name change this guideline is now called "**Management of Pregnancy with Coil in Situ"**	Gynae and Fertility Clinical Governance Group	18th October 2025

1.0 Introduction

The risk of a woman becoming pregnant with either a Mirena IUS or a copper IUCD is very low. If a woman falls pregnant with either type of intrauterine contraception there is a high risk of ectopic pregnancy in the region of 1 in 20 cases. Therefore additional measures and caution should be taken to investigate for a possible ectopic pregnancy. Where the coil is left in situ, there is a significantly increased risk of miscarriage around 50-60% compared to a background rate of 13%[1]. If pregnancy occurs with an IUD *in situ*, removal of the IUD to avoid the risk of miscarriage, preterm delivery and infection is recommended by the UKSPR.[2] This should be done as soon as possible after confirmation of pregnancy prior to 12 weeks in the context of a viable pregnancy.

2.0 Aim(s)

The aim of this guideline is to ensure the optimum care is given and to provide a framework for appropriate management

3.0 Objectives

3.1 To ensure appropriate management is given to the patient
3.2 To give adequate care and support to a patient with an unplanned pregnancy with an intrauterine device in situ

4.0 Definitions

4.1 The confirmation of an ongoing intrauterine pregnancy with an intrauterine device in situ

5.0 Process

5.1 Initial Assessment

- Confirm coil in situ by completion of history/assessment sheet, referral letter or verbal confirmation.
- Ascertain gestation via LMP
- Perform EPAS scan at 6 weeks where the LMP is known and if the patient is well. If the LMP is not known then perform scan at next available appointment.
- Where the initial scan does not reveal a pregnancy manage as per PUL and consider early referral to Consultant led complex patient clinic (Tuesday Afternoon EPAS)
- Discuss scan findings in detail, including viability of pregnancy and plan of care, position of coil if visible on the scan
- Obtain coil history i.e length of time coil in situ, reasons for coil, previous problems or discharge
- Check temperature, pulse and bp

5.2 Further Management

Copper IUCD

- Arrange for a Gynaecological Doctor (usually on call doctor) to make an assessment
- Doctor to discuss the pros and cons of removal of the coil and keeping it in situ
    - FSRH, UKSPR and NICE guidance is that the coil should be removed prior to 12 weeks, whether or not they intend to continue the pregnancy
    - The process of removing the coil my initiate a miscarriage however the risk is likely to be higher if left in situ
    - If the patient is beyond 12 weeks, then usual practice would be to leave the coil in situ.
    - The copper coil in itself is not known to be teratogenic.

Mirena IUS

- Arrange for a Gynaecological Doctor (usually on call doctor) to make an assessment
- Doctor to discuss the pros and cons of removal of the coil and keeping it in situ
    - FSRH, UKSPR and NICE guidance is that the coil should be removed prior to 12 weeks, whether or not they intend to continue the pregnancy
    - The process of removing the coil my initiate a miscarriage however the risk is likely to be higher if left in situ
    - In case of an accidental pregnancy with Mirena in situ, ectopic pregnancy should be excluded and the system must be removed and termination of the pregnancy should be considered. Removal of Mirena or probing of the uterus may result in spontaneous abortion. Should these procedures not be possible, the woman should be informed about increased risk of spontaneous abortion or premature labour observed during the use of copper and plastic IUDs. Accordingly, such pregnancies should be closely monitored. The woman should be instructed to report all symptoms that suggest complications of the pregnancy, like cramping abdominal pain with fever. (ref SPC)
    - Theoretical concerns exist around the local exposure to Levonorgestrel, however any potential risk of teratogenicity is not confirmed in the literature.
    - If the pregnancy is continued with the Mirena IUS in situ, consideration should be given to referral to fetal medicine antenatally in view of theoretical teratogenicity.

For both types of coil:

- If the patient agrees to removal of the coil, verbal consent must be documented in the patient notes, and on Maternity Information System, and the coil then removed if the strings are visible
- If the cervix is clearly visualised and the strings not seen then no further attempt should be taken to remove the coil
- HVS to be obtained if it is felt to be appropriate by the examining doctor and ensure HVS report is checked and action taken as recommended
- Staff to discuss with the patient signs of infection and symptoms of threatened miscarriage
- Contact numbers to be given
- Full EPAS summary on Maternity Information System and send to the GP
- If the patient wishes to keep the coil in situ at present inform her GP on EPAS scan report letter

5.3 Patient Involvement

- All patients are to be seen by a member of EPAS staff
- Scan findings to be discussed
- Patient to be involved at all levels in care pathway
- Support to be given to the patient regarding unplanned pregnancy
- Further support to be made available and contact numbers to be given.

6.0 Training

6.1 All staff receive continuous in house training and receive regular updates from The Association of Early Pregnancy Units

6.2 All staff employed by SATH will be informed how to access guidelines on the intranet

6.3 Information regarding new and updated guidelines is circulated by email/memo to medical and nursing staff

6.4 A paper copy is placed in the Gynaecology Guideline Folder on Ward 14 and file in EPAS

References:

NICE Guideline cg30: Long Acting Reversible Contraception Sep 2014
https://www.nice.org.uk/guidance/cg30/chapter/1-recommendations

Faculty of Sexual & Reproductive Healthcare. Intrauterine Contraception. 2015.
https://www.fsrh.org/standards-and-guidance/documents/ceuguidanceintrauterinecontraception

Summary of Product Characteristics: Mirena IUS (March 2018)
https://www.medicines.org.uk/emc/medicine/1829/SPC/Mirena