THE USE OF IUD IN NULLIPARAE

Clinical experiences

T. FEDE

Department of Obstetrics and Gynecology, University of Padua (Italy)

SUMMARY

The Author describes the risks involved in the use of IUD by nulliparae. On the basis of her personal series she explains the conditions allowing the gynecologist to satisfy the patient's request or even suggest this method himself.

Uteroadnexal infections are among the main contra-indications to the use of IUD but can also be complications induced by the presence of IUD in the uterine cavity ([1, 2, 3, 4]). Several Authors have reported and described these complications in a high percentage of cases, in the most serious forms too ([5, 6, 7, 8, 9]).

This pessimistic picture is counterbalanced by studies by other Authors ([10, 11, 12, 13]) leading to far more optimistic results with regard to the importance of endometrial phlogoses and fertility restoration after removal of an IUD. Special consideration must be devoted to the use of IUD by nulliparae. In these cases the possibility of later pregnancies is the main concern of the gynecologist.

When there are no contra-indications the following factors must be taken into account in deciding whether to apply an intrauterine device to a nullipara: psychologic or physical conditions preventing the use of hormonal contraceptives; occurrence of frequent and regular sexual intercourses; need for safe contraception.

Furthermore this method must be resorted to when one or more voluntary interruptions of pregnancy in the patient's anamnesis add up to the above mentioned factors.

MATERIAL AND METHODS

This study concerns 47 nulliparae who asked for the application of contraceptive IUD. The patients were between 18 and 29 years of age, middle-class and with average or middle-high education. Table I reports the indications for the use of IUD: 11 patients reported at least 1 voluntary interruption of pregnancy; 29 reported regular sexual intercourses (2 or more per week); 8 patients reported both previous VPI and regular sexual activity. The following contra-indications were observed: uterine hypoplasia in 12 patients; algomenorrhea in 13; both conditions in 7 patients and relapsing vulvovaginites in 8.

The bottom section of the table lists the contraceptive methods that were prescribed.

IUD were applied to 14 patients (29.7%). They all reported regular sexual life and 11 reported at least 1 VPI in their anamnesis. They

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Table 1. — *Reasons for gynecologist's choice to apply IUD; contra-indications to this method and contraceptive methods prescribed in a group of nulliparae.*

Reasons for gynecologist's choice to apply IUD	No. cases	
Previous VPI	11	(23.4%)
Sexual activity 2 or more int. / week	29	(61.7%)
No reason	7	(14.9%)
Total	47	(100 %)
Contra-indications to IUD application		
Uterine hypoplasia	12	(25.6%)
Algomenorrhea	13	(27.6%)
Relaps. vulvovaginitis	8	(17 %)
No contra-indication	14	(29.8%)
Total	47	(100 %)
Prescribed contraceptive methods		
IUD	14	(29.8%)
Estro-progestinics	22	(46.8%)
Barrier methods	11	(23.4%)
Total	47	(100 %)

refused hormonal contraception mainly for psychological reasons. Some of them had applied to a Psychologist for advice but, in the meantime and in the absence of other contra-indications, no reason was seen to delay the contraceptive protection these patients had asked for. 22 patients, after informative talks on contraception and satisfactory clinical tests, chose hormonal contraception; 11 patients with occasional sexual intercourses chose barrier methods. In the 14 cases of IUD application, copper devices, sometimes 'mini' types, were used. In no case was the device rejected at 1 or 3 months from its application. The six-monthly periodical checks showed that the method was tolerated satisfactorily. No patient reported menometrorrhagia or algomenorrhea. 5 of them reported pre- and post-menstrual spotting over the first 3 or 4 months following the application of an IUD.

CONCLUSION

The risk of IUD-induced pelvic phlogosis in nulliparae prevents a large-scale use of intrauterine devices in these patients. However, in the absence of other contra-indications, this method is viable for nulliparae too, especially when its non-application exposes the patient to more serious risks like unwanted pregnancies or when estroprogestinic contraception cannot be resorted to.