FSRH CEU statement on antibiotic cover for urgent insertion of intrauterine contraception in women at high risk of STI
22 May 2019

There is potential risk of ascending pelvic infection associated with insertion of intrauterine contraception (IUC) in women with existing bacterial STI; BASHH guidance indicates that risk is highest in women with *Chlamydia trachomatis* or *Neisseria gonorrhoeae* infection.[1] All women requesting insertion of IUC should therefore be individually assessed regarding risk of sexually transmitted infection (STI).

In most circumstances, women assessed as being at high risk of STI can be tested, the results obtained and appropriate treatment completed before IUC insertion. Effective bridging contraception should be provided to reduce pregnancy risk during the wait for IUC insertion.[2] However, IUC insertion (particularly insertion of a copper IUD for emergency contraception) cannot always be delayed.

Asymptomatic women at high risk of STI can, if required, proceed with IUC insertion without waiting for the results of STI testing, so long as they can be contacted and treated promptly in the event of a relevant positive result - antibiotic cover is ***not*** required.[3]

Women who have urogenital symptoms suggestive of STI should usually delay insertion of IUC for routine contraception.[4] Bridging contraception should be used until results of STI testing are available, treatment completed and symptoms resolved. If, however, *immediate* insertion of a copper IUD for emergency contraception is required, IUD insertion with antibiotic cover could be considered.[3] Clinical judgment based on the nature and severity of symptoms and discussion with the woman are required.

Choice of antibiotic cover for symptomatic women requiring immediate insertion of IUC

BASHH guidance changed in 2018 and now advises against use of single-dose azithromycin 1g for any indication. The change is due to emerging resistance of *Mycoplasma genitalium* to macrolide antibiotics as well as inadequate treatment of rectal Chlamydia infection by single dose azithromycin (note that significant numbers of women with urogenital infection also have rectal infection regardless of history of anal intercourse).[5]

BASHH now recommends doxycycline 100mg twice daily for 7 days as first line treatment for uncomplicated Chlamydia infection. Doxycycline is the first line antibiotic for women at high risk of Chlamydia who have urogenital symptoms and require immediate IUD insertion. There is, however, a very small risk of ongoing pregnancy despite IUD insertion and possible concerns surrounding use of doxycycline early in pregnancy should be discussed with the woman. Evidence relating to fetal exposure to doxycycline in the very early first trimester of pregnancy is extremely

limited; most concerns relate to use in the second trimester. First trimester doxycycline exposure has not been firmly associated with any specific malformation and Toxbase.org advises that use may be considered where clinically appropriate.[6] However the British National Formulary restricts use of doxycycline in the first trimester to malaria prophylaxis only.[7]

A woman may, after discussion, wish to avoid treatment with doxycycline if she thinks she would continue with a pregnancy in the event that the emergency IUD fails. In this situation, or if there is concern about adherence to doxycycline treatment, the BASHH second line Chlamydia treatment option (azithromycin 1g as a single dose followed by 500mg daily for 2 days) could be considered.

Where there is high risk of gonorrhoea infection, ceftriaxone 1g IM stat is recommended first line as per BASHH guidance (note that azithromycin is no longer recommended in addition to ceftriaxone in the treatment of gonorrhoea).[8]

References

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