absence of the device in the uterus.

If the device is not located and pregnancy has been excluded, a plain abdominal x-ray should be ordered to check for perforation of the uterus and device migration. Removal of extrauterine devices is determined on a case-by-case basis in the tertiary setting. If the device is appropriately located in the uterus it can be safely left until removal is desired.

Infection in the context of IUC use

There is a small risk of insertion-related infection in the first 20 days after IUC device insertion[15] and women should be advised to return for early review if symptoms occur. All women with symptoms and signs suggestive of PID who have an IUC device in situ must have a course of antibiotics initiated immediately, with review after 48 hours, or be referred to hospital if symptoms are severe.[16] If the condition has improved within 48 hours the IUC device may be retained but if there is no improvement, it should be removed.

IUC users at risk of STIs should be advised about the simultaneous use of condoms. Women who contract chlamydia or gonorrhoea without any signs or symptoms of PID can be treated according to the *Australian STI Management Guidelines for Use in Primary Care*[17] and, if desired, the IUC device can be retained.

Conclusion

IUC provides highly effective and cost-efficient contraception for women across the reproductive lifespan from young nulliparous women to women at the time of the perimenopause. The MEC framework supports the safe provision of IUC for women who make an informed decision to use this method of contraception. MT

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