



Care
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Vasovagal syncope (cervical shock) during IUD insertion

Vasovagal syncope refers to a vasovagal episode associated with pain, emotional stress or specifically cervical instrumentation or dilatation, sometimes referred to as 'cervical shock'. Advising patients to move ('wiggle' their fingers and toes) can help if they are feeling lightheaded. Mild symptoms during or within 20 minutes of the IUD insertion are common, requiring additional time with the patient lying down, followed by careful and slow progression to sitting, drinking water and having something that contains sugar to eat. Cervical shock/vasovagal syncope resulting in loss of consciousness and/or needing treatment with atropine is uncommon. It is important to have atropine and other equipment required for the management of vasovagal syncope available, accessible, clearly labelled and adequately maintained, with their location known to all staff. Bradycardia is defined as a heart rate of less than 60 per minute. Most people do not get symptoms until the heart rate is less than 40 per minute.

Symptoms and signs of vasovagal syncope:

- Patient complains of feeling faint, dizzy or light-headed
- Slow pulse rate/bradycardia
- Low blood pressure
- Pallor and sweating
- Nausea and vomiting
- Loss of consciousness

Initial management of vasovagal syncope:

Use the ABCDE approach (Airway, Breathing, Circulation, Disability, Exposure) Stop further manipulation/dilatation of cervix/instrumentation of the uterus Call for help Assess the patient

1. If severe pain, stop the procedure or remove the IUD
2. Keep the patient lying with head down and legs elevated
3. Monitor BP and pulse
4. Reassure the client
5. Press the duress button if more assistance needed
6. If becomes unresponsive or displays signs of shock (pallor, sweating, feeling faint or nauseous), administer high flow oxygen (10-15L per min)
7. Attach a pulse oximeter if not already applied and titrate oxygen to achieve saturation levels of 94-98%
8. **If not recovering, has diminished consciousness and pulse under 60/min, secure IV access and give ATROPINE 0.6MG IV (= 1 ampoule), followed by a saline flush; if vein not accessible, give IM by deep injection into mid-thigh**

Repeat atropine doses in 5-15 minute intervals, if necessary, to a maximum of 3mg total

9. If no response after 1.2 MG (=2 ampoules) atropine and fluids, commence the ANZCOR and connect AED pads for confirmation of sinus bradycardia before giving further doses of atropine.
10. Record the dose and time of all medications, and continue to monitor heart rate, blood pressure, oxygen saturation, and cardiac rhythm.
11. Once pulse and blood pressure recover, slowly raise the patient to a seated position.
12. Discharging the patient home may be an option if there was a good response to the initial dose of atropine, and full patient recovery after a brief period of observation e.g., 30 minutes. If any concerns or 2 or more doses of atropine were required, refer the patient to the emergency department.
13. Ambulance transport may be required
14. Patients should generally not drive home, although this can be assessed on a case-by-case basis.

Any patient with an inadequate response, deterioration or other life-threatening problems should be taken immediately to hospital by the emergency services

References 1. College of Sexual and Reproductive Health Care. FSRH Service Standards for Resuscitation in Sexual and Reproductive Healthcare Services. 2022.
<https://www.cosrh.org/Common/Uploaded%20files/documents/service-standards-for-resuscitation-in-sexual-and-reproductive-healthcare-2022.pdf>

