


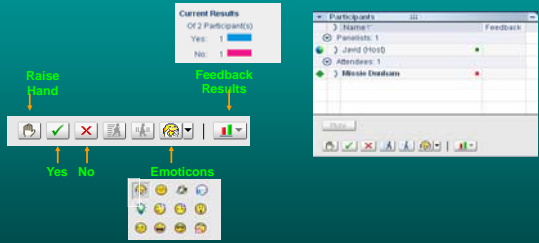
# Management of Difficult IUC Cases

Michael S. Policar, MD, MPH  
Dept of OB,GYN, and Reproductive Sciences  
UCSF School of Medicine


January 13, 2010



## Tools you can use – Feedback Toolbar

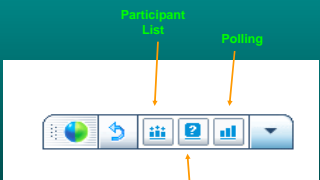


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## Floating Toolbar

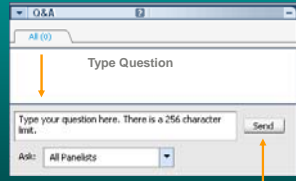
- Use the floating toolbar to communicate in today's session.




3



## Q&A



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## Evaluation and Other Forms


At the conclusion of session complete:

1. Evaluation Form
2. Post Test
3. Continuing Education Form
4. Sign-in Sheet

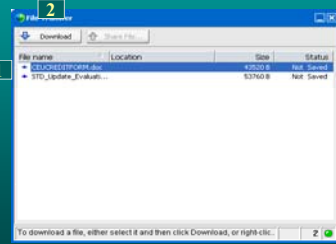
Forms can be downloaded at the end of this session by file transfer.

Those without web access can get forms by calling 1-877- FAMPACT

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## File Transfer



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**Management of Difficult IUC Cases**

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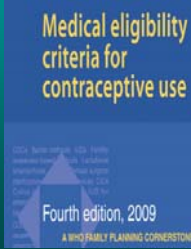
January 13, 2010

There are no relevant financial relationships with any commercial interests to disclose

**Learning Objectives**

- Explain the optimal timing of IUC insertion for women using no method, other methods, and those that are postpartum or postabortion
- List 3 steps in the management of vasovagal syncope
- List 3 interventions to facilitate IUC insertion in women with cervical stenosis

- WHO *Medical Eligibility Criteria* for Contraceptive Use – 4<sup>th</sup> edition - 2009  
 – [http://www.who.int/reproductivehealth/publications/family\\_planning/9789241563888/en/index.html](http://www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html)
- [www.reproductiveaccess.org/contraception/WHO\\_chart.htm](http://www.reproductiveaccess.org/contraception/WHO_chart.htm)
- **US Medical Eligibility Criteria**
  - Developed by CDC in 2009
  - To be published in MMWR 2010



**WHO Medical Eligibility Criteria**

Category	Definition	Recommendation
1	No restriction in contraceptive use	Use the method
2	Advantages generally outweigh theoretical or proven risks	More than usual follow-up needed
3	Theoretical or proven risks outweigh advantages of the method	Clinical judgment that this patient can safely use
4	The condition represents an unacceptable health risk if the method is used	Do not use the method

**2009 WHO Medical Eligibility Criteria Both IUC Products**

Category 4	Category 3
<ul style="list-style-type: none"> <li>• Puerperal sepsis</li> <li>• Post-septic abortion</li> <li>• Unexplained vaginal bleeding</li> <li>• Malignant GTD or ↑ hCG</li> <li>• Cervical/endometrial cancer</li> <li>• Uterine anomaly/fibroids*</li> <li>• Current GC/CT/purulent cervicitis/PID/pelvic TB</li> </ul>	<ul style="list-style-type: none"> <li>• Postpartum (48h-4 wk)</li> <li>• Benign GTD with ↓ hCG</li> <li>• Increased risk of STIs **</li> <li>• AIDS (not clinically well)</li> </ul>

\* with distortion of cavity      \*\* very high individual risk of exposure to GC or Ct

### 2009 WHO Medical Eligibility Criteria

	Category 4	Category 3
LNG-IUS only	Current breast cancer	<ul style="list-style-type: none"> <li>Breast cancer (<math>\geq 5</math> yrs NED)</li> <li>Liver tumors, severe cirrhosis</li> <li>Current DVT/PE</li> <li>Current MI or angina</li> <li>Migraines with aura</li> </ul>
Copper IUC only		<ul style="list-style-type: none"> <li>Severe platelet reduction</li> </ul>

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### IUC Complications

	Absolute risk	Comment
Infection (PID)	1-2/TWY	Same as gen'l population
Perforation	1/1,000	Mostly benign
Expulsion	1-6/100	Most are self-recognized
Pregnancy	<1/HWY	Minimal impact if removed early in pregnancy

HWY: per 100 women per year  
TWY: per 1,000 women per year

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### Ms A: "I'm Just Finishing High School"

- Ms A is an 18 year old G<sub>1</sub> P<sub>0</sub> TAB<sub>1</sub> woman requesting a change in contraceptive method
- Has used OCs and the patch in the past, but has trouble remembering to use them correctly...now using condoms "most of the time"
- Sexually active with her current boyfriend for 3 months; 4 lifetime sexual partners
- First intercourse 18 months ago
- Past medical history unremarkable
- Exam: weight: 189 lbs, ht: 5'6", BP: 110/82

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### Ms A: Clinical Dilemmas

- Use of IUC by nulliparous adolescent relative to STI risk and consequent infertility
- Screening test necessity and timing
- Need for a post-IUC insertion follow up visit
- IUC insertion issues in obese women
- Insertion difficulty in nulliparas
- Insertion pain in nulliparas

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### Indications for IUC Use

- Both IUC products
  - Long term contraception in fertile women
- WHO-MEC for IUD Use
 

Menarche to age 20	WHO-2
Age 20 and older	WHO-1
- Nulliparity WHO-2
- Parous WHO-1

WHO Medical Eligibility Criteria for Contraceptive Use, 2009

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### IUC Use in Nulliparous Women

- Use of IUCs by nulliparous women with low risk of PID is safe and effective<sup>1-4</sup>
- LNG-IUS is appropriate for nulliparous women with menorrhagia and/or dysmenorrhea
- IUC expulsion, bleeding, and pain are slightly more likely among nulliparous women<sup>2-5</sup>

Suhonen S. *Contraception* 2004;69:507-512  
Nelson AL. *Obstet Gynecol Clin North Am.* 2000;27:723-740  
Dardano KL, Burkman RT. *Am J Obstet Gynecol.* 1999;181:1-5  
Li C. *Contraception* 2004;69:247-250  
Trelman K, et al. *Population Reports.* 1995

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**IUCs Do Not Cause PID**

- PID incidence for IUC users is similar to that of the general population
- Risk is increased only during the first month after insertion
- Preexisting STI at time of insertion, not the IUC itself, increases risk
- No reason to restrict use based on sexual behaviors

Svensson L, et al. JAMA. 1984.  
Sivin I, et al. Contraception. 1991.  
Farley T, et al. Lancet. 1992.

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**Pre-IUC Insertion Screening**

- Evidence supports *no* routine screening tests
  - Ct, GC: if high risk sexual behaviors or <26 yo and annual screening Ct not yet performed
  - Pregnancy test: only if pregnancy suspected
  - Pap smear: if due for a scheduled Pap (in her case, Pap unnecessary since < 3 years from sexual debut)
  - Hematocrit: only if anemia suspected
- Any indicated screening test can be done on the day of IUC insertion

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**Pre-Insertion Guidelines**

- Prophylactic antibiotics
  - No value based on randomized clinical trials
- Premedication
  - NSAID 30-60 minutes before insertion is provided commonly, but two small studies have mixed results regarding the effect on pain score during and after insertion procedure

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**Is A Follow Up Visit Necessary?**

- Practices vary widely in the US
- Two studies by WHO in Africa with non-medicated IUCs conclude that follow-up visit is unnecessary
- Arguments for routine follow-up visit
  - Opportunity for further counseling, esp if high risk for discontinuation due to bleeding changes
  - Early asymptomatic expulsion may be found
  - Medico-legal “standard of practice”?
- Arguments against routine follow-up visit
  - All adverse effects other than expulsion have symptoms

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**Is A Follow Up Visit Necessary? Post-IUC Insertion Counseling**

The client should return if...

- The string cannot be located (use barrier method until placement is confirmed)
- Symptoms of pregnancy are present
- Symptoms of infection are present
  - Abdominal or pelvic pain, deep dyspareunia, fever, vaginal discharge
- Sudden unexplained pelvic pain occurs
- Excessively heavy bleeding

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**IUD Insertion: Tricks of the Trade**  
A Clinical Update on Intrauterine Contraception@arhp.org

- For pain management
  - Oral NSAID
    - Naproxen sodium 440-550mg
    - Ibuprofen 600-800mg
  - Instill lidocaine in uterine cavity with an endometrial sampler
  - An endometrial sampler can be used instead of sound to measure depth of uterus

more...  
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**IUD Insertion: Tricks of the Trade**  
 A Clinical Update on Intrauterine Contraception @arhp.org

- To visualize cervix
  - Use large speculum
  - If vaginal walls obscure cervix, cut off end of condom or finger of a glove and slip over metal speculum
  - Get better light
- For women with narrow cervical canal
  - Misoprostol 400 mcg sublingual or buccal 1+ hours before insertion

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**Os Finder** **Pratt Dilators**

Superior Medical offers reusable (white) and Cervical Locator and a Fundus Dilator. They are used to locate the cervical canal and the internal OS.

Order # SMI-391-870 Set of 3

Cervical Os Finders (Disposable Box/25) \$ 49.00  
 Cervical Os Finder Set (Reusable Set of 3) \$ 69.00

**Cervical priming with sublingual misoprostol prior to insertion of an intrauterine device in nulliparous women: a randomized controlled trial**

- 80 nulliparas treated 1 hour prior to IUD insertion
  - Misoprostol 400 mcg SL and diclofenac 100 mg
  - Diclofenac 100 mg PO alone (control group)
- Findings
  - Insertion easier with misoprostol than control group
  - Pain scores no different in the two groups
  - Most side effects equal
    - Shivering, diarrhea more common in misoprostol group

Saav I et. al., Human Reproduction 2007; 22, (10): 2647

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**Misoprostol for IUC Insertion**

Table 2: Difficulty of IUD insertion, as estimated by the inserter

Estimation of difficulty of insertion	Misoprostol group, n = 39 (%)	Control group, n = 40 (%)
Easy	29 (74.4)	22 (55.0)
Intermediate or difficult	10 (25.6)	18 (45.0)

P = 0.039; Fisher's Exact test, mid-P-value. Degrees of freedom = 1.

- Conclusion
  - Misoprostol facilitates IUD insertion and reduces the number of difficult and failed attempts of insertions in women with a narrow cervical canal

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**Paracervical Block**

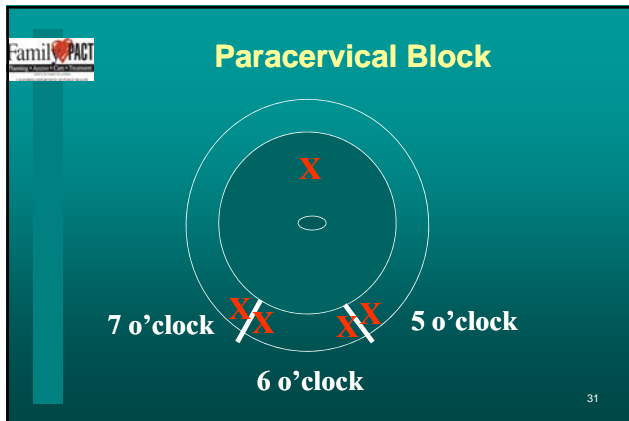
- Target is uterosacral ligaments
- Inject at reflection of cervico-vaginal epithelium
- 2 (5, 7 o'clock) or 4 sites (4,5,7,8 o'clock) submucosally to depth of 5 mm
- Use spinal needle or 25g 1 1/2" needle + extender
- Moore-Graves speculum allows for more movement
- Tips
  - Start with 1/2-1 cc. at tenaculum site
  - Disguise pain of needle insertion with cough
  - WAIT 1-2 minutes for set up before procedure

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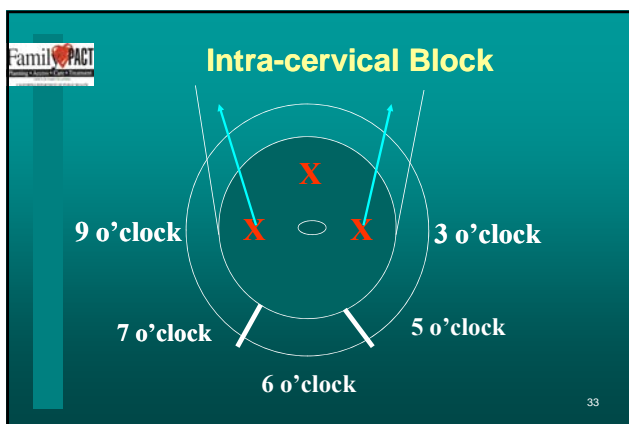
**Paracervical Block**

7 o'clock X 5 o'clock

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- 
- Intra-cervical Block**
- Targets the paracervical nerve plexus
  - 1 ½" 25g needle with 12 cc "finger lock" syringe
  - Inject ½- 1 cc. at 12 o'clock, then apply tenaculum
  - Angulate needle at the hub to 45° lateral direction
  - At 3 or 9, insert needle into cervix to the hub 1 cm lateral to external os, aspirate
  - Inject 4 cc of local, then last 1 cc while withdrawing
  - Rotate barrel 180°, then inject opposite side
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- 
- Intervention Steps:  
"The Narrow Cervical Canal"**
- Use greater outward traction on the tenaculum to minimize canal-to-cavity angulation
  - Place paracervical or intracervical block to relax cervical smooth muscle and reduce pain
  - Use os finder device, if available
  - Dilate internal os with Pratt dilators to #13F (4.1 mm)
  - If unsuccessful, return at a later date with use of misoprostol cervical priming
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- 
- Ms B: "I Faint Easily"**
- Ms B is a 25 year old G<sub>0</sub> P<sub>0</sub> woman requesting IUC insertion
  - She states that she has had a number of fainting episodes in the past...most recently at the dentist and another during a HPV vaccine injection
  - She has told her PCP about this problem...heart auscultation and an ECG were normal.
  - Are there any special precautions for her IUC insertion?
- 35

- 
- Lightheadedness and Syncope**
- **Vasovagal attack**
    - Due to bradycardia + peripheral vasodilation
    - Prevention: advise patient to be well fed and hydrated prior to insertion
    - Management
      - Isometric muscle contractions of extremities
      - Patient should remain supine; elevate legs
      - If heart rate <60, give atropine 0.4 mg IV
- Grubb BP N Engl J Med 2005 352:1004 36

**Lightheadedness and Syncope**

- **Hyperventilation**
  - Due to low CO<sub>2</sub> levels (respiratory alkalosis)
  - Heart rate normal or tachycardia
  - Treat with shallow breaths or re-breathing bag
- **Local anesthetic toxicity (if cervical block)**
  - CNS: lightheadedness, restlessness, anxiety, tinnitus, tremor, twitch, perioral numbness, visual changes, seizure, respiratory arrest
  - CV: bradycardia, arrhythmia, hypotension

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**Ms C: “Can I Have an IUC After I Deliver?”**

- Ms. C is a 25 year old G<sub>3</sub> P<sub>2</sub> at 34 weeks with a single pregnancy
- During her 34 week prenatal visit, post-partum contraception options were reviewed
- She states that she used a IUC when she was 20 and would like to use the method again
- She asks whether the IUC can be inserted immediately after she delivers

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**2009 WHO MEC: Postpartum IUC Insertion**

	Cu-IUD	LNG-IUD	Comment
< 48 hours	1	1/not BF 3/BF	Evidence: There was some increase in expulsion rates with immediate insertion compared to delayed postpartum insertion and interval insertion.
48 hours to 4 weeks	3	3	
> 4 weeks	1	1	

- Insert IUC within 15 minutes of placental delivery
  - Use sponge forcep on cervical lip; 2<sup>nd</sup> forcep to insert
  - Cut string flush with external cervical os
- Can insert at time of caesarean section

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**IUC Use During Lactation**

- Effectiveness not decreased
- Uterine perforation risk unchanged
- Expulsion rates unchanged
- Decreased insertional pain
- Reduced rate of removal for bleeding and pain
- LNG comparable to copper T in breastfeeding parameters

Chi I-C, et al. *Contraception*. 1989  
Shaamash AH, et al. *Contraception*. 2005

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**Post Abortion IUC Insertion (WHO MEC, Cochrane Review)**

- No difference in complications for immediate versus delayed insertion of an IUC after abortion
- Expulsion greater when an IUC was inserted following a 2<sup>nd</sup> trimester vs. a 1<sup>st</sup> trimester abortion
- There were no differences in safety or expulsions for post-abortion insertion of an LNG-IUS vs. Cu-IUC

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**Impact of Immediate Postabortal Insertion of IUC on Repeat Abortion**  
Goodman S, *Contraception* 2008;78:143-148

- Conducted at N. CA Planned Parenthood sites 2002-2005
- Retrospective cohort study design
  - Cases: 673 women with post-AB IUC insertion
  - Controls: 1,346 women using other contraceptives
  - Followed for 14 months after abortion procedure
- Results
  - IUC group: 36.4 abortions per 1000 woman-years
  - Controls: 91.3 abortions per 1000 woman-years
  - Adjusted relative risk= 0.37 (0.26-0.52)

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### Post Abortion IUC Insertion Implications

Goodman S, Contraception 2008;78:143-148

- Of 1.3 million abortions annually in US, about half are repeat procedures
- 40% of women scheduled for delayed IUC insertion did not return for the procedure
- Up to 83% of women ovulate with the first cycle after the procedure
- Immediate post-abortion IUC insertion is a safe, effective, practical, and underutilized intervention that can reduce repeat unintended pregnancy and repeat abortion *by two-thirds*

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### Ms D: "I Have Fibroids"

- Ms D is a 35 year old G<sub>0</sub> P<sub>0</sub> woman who is seen for contraceptive counseling
- Over the past 2 years, her periods have been heavier and longer than previously
- Bimanual exam: Irregular 12 week size uterus
- LNG-IUS chosen for contraception and bleeding control
- Clinical dilemmas...
  - LNG-IUS control of fibroid-related bleeding
  - Technical IUC insertion issues with uterine fibroids

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Mirena® is Now Also Approved for the treatment of heavy periods in women who choose intrauterine contraception.

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Boyer Press Release • FDA Press Release

### LNG-IUS vs Oral MPA for Heavy Menstrual Bleeding

- Randomized parallel-group trial comparing Mirena (n=79) to MPA (n=81), over 6 cycles
- Exclusions: organic or systemic conditions causing heavy bleeding (except small fibroids, not > 5 mL)

Figure 10. Median Menstrual Blood Loss (MBL) by Time and Treatment

Time	Mirena (mL)	MPA* (mL)
Baseline	147.96	154.20
Mid-Study	30.30	135.20
End of Study	7.10	121.47

\*MPA=mexdroxyprogesterone acetate

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### Figure 11. Proportion of Subjects with Successful Treatment

Treatment	% Subjects
Mirena	85%
MPA*	22%

$P < 0.001$

\*MPA= mexdroxyprogesterone acetate

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### Menstrual Blood Loss Before and After Placement of the LNG-IUS

Time	Mean Menstrual Blood Loss (mL per month)
Baseline (mean of 2 cycles)	~120
6 mo	~20
12 mo	~25
24 mo	~10
36 mo	~15

\* Mean with standard deviation.  
Xiao B, et al. Fertil Steril. 2003;79:963-969.

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**Comparison of medical therapies for heavy menstrual bleeding**

	NSAIDs	OCS	DMPA	LNG-IUS
Dosing	Variable	Daily	3 months	5 years
Effects on blood loss	Reduction	Reduction	Reduction	Reduction
Side effects	GI	Hormonally related	Hormonally related	Occasional hormonal
Contraceptive effectiveness	None	Middle tier	Middle tier	Top tier
Typical-use 1-yr pregnancy rate	Unchanged	8%	5%	0.1%

DMPA, depot medroxyprogesterone acetate; GI, gastrointestinal; LNG-IUS, levonorgestrel-releasing intrauterine system; NSAIDs, nonsteroidal anti-inflammatory drugs; OCS, oral contraceptives.

**Grimes DA. Review of Management Strategies for Heavy Menstrual Bleeding: Summary of the Best Evidence. OBG Management 10/2009**

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### LNG-IUS and Fibroids

- **Small studies with mixed results**
  - Mercurio (2003): 75% persistent menorrhagia
  - Starczewski (2000): 92% reduced bleeding
- **Recommendations**
  - Off-label use; may violate precaution regarding cavity depth and distortion of uterine cavity
  - Reasonable to attempt treatment with Mirena
  - Documentation of informed consent content a must

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### Tips for IUC Insertion in Women with Fibroids

- **Determine fibroid location by ultrasound\***
  - Fundal fibroids (intramural, sub-serous) that do not distort uterine cavity do not preclude IUC use
  - Large sub-mucous fibroids, especially in lower uterine segment, contraindicate IUC use
  - Evaluate for other pathology, e.g., polyp
- **Ultrasound guidance\*** may facilitate safe placement
- **No data on efficacy, but probably not compromised with LNG-IUS or with Cu-T if fundal placement**

**\* Not Family PACT benefits**

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### Ms E: “What Was That Pain?”

- Ms E is a 39 year old G<sub>2</sub> P<sub>2</sub> is seen for her 6 week post-partum visit after a NSVD...requests Cu-T
- She is lactating, no longer bleeding, and doing well
- Exam shows a 8-9 week size uterus that is firm and non-tender; adnexal exam negative
- During sounding, moderate resistance is encountered at the internal os...then sounded to 14 cm.
- She complained of pain only during the initial part of the sounding procedure
- **What’s going on here??**

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### Uterine Perforation

- **More likely to occur in relation to**
  - Posterior uterine position
  - Skill/experience of provider
  - Insertion 2 days-4 weeks after childbirth
- **Typical location is midline at uterine fundus...if so, perforation often is asymptomatic, benign**
- **Suspect if sounding is much deeper than expected or if ↑ resistance followed by none at fundus**
- **Easily confirmed by office ultrasound, if available**

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### Management of Uterine Perforation

- **If before** insertion of IUC, stop procedure
- **If during** insertion of IUC, remove IUC
- **Monitor for 30 min** for excessive bleeding, pain
- **Provide alternative method of contraception**
- **Can insert another device after next menses**

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### Prevention of Uterine Perforation

- Why sound the uterus at all?
  - Determine the “pathway” to the fundus
  - Preliminary dilation of the internal os
  - Establish depth to fundus to set flange
  - Ensure depth within 6-10 cm limits
- Bend sound to mimic uterine flexion
- Brace fingertips on speculum to achieve control of force while advancing the sound
- EMB device can be used instead of metal sound
- Open IUC package *after* sounding completed

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### Ms F: “I Can’t Feel The String”

- 50 yo G<sub>3</sub> P<sub>3</sub> whose IUC was inserted 8 years ago
- She remembers that it had a T shape, but not sure which type of IUC was inserted
- She has not been able to feel the string for the past 2 months, but before that checked irregularly
- Speculum exam shows that the string is not present at the external cervical os
- **Clinical dilemmas**
  - Determination of IUC location
  - Extraction of IUC without visible string

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### Uncomplicated IUC Removal

- Indications
  - Patient desires pregnancy
  - Expiration date reached
  - Unacceptable side effects
  - Failure (pregnancy)
- Menopause
  - Strings seen: remove
  - No strings: weigh benefit vs. hazard of removal
  - Tail-less IUC (e.g., stainless steel coil ring) does not require removal unless requested by patient

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### Missing IUC String: Diagnosis

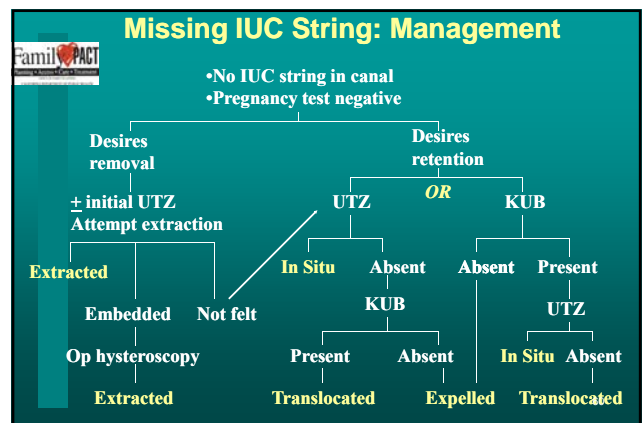
- Possibilities...
  - Expulsion, pregnancy, embedment, translocation
- Initial management
  - Probe for strings in cervical canal
    - Cytology brush to tease from canal
    - Endocervical speculum or forceps
  - Office pregnancy test
  - Office ultrasound, if available (TAR required)
  - Prescribe back-up contraceptive method until intrauterine location is confirmed


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### IUC Expulsion

- Occurs in 2-10% IUC insertions within first year
- Risk of expulsion related to
  - Provider’s skill at fundal placement
  - Age, parity, uterine configuration
  - Time since insertion (↑ within 6 mos)
  - Timing of insertion (menses, postpartum, post-abortion)
- Asymptomatic expulsion often presents with an (unanticipated) pregnancy
- Partial expulsion may present with
  - Pelvic pain, cramps, intermenstrual bleeding
  - Pregnancy

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### Pregnancy With IUC In Situ

- Determine site of pregnancy (IUP or ectopic)
- If termination planned, await TAB to avoid triggering spontaneous abortion (SAB)
- If continuing IUP
  - If strings visible, remove IUC to decrease risk of SAB, premature delivery compared to retention
  - If strings not visible, do not attempt removal
    - Increase surveillance for SAB, pre-term birth
    - No greater risk of birth defects, since IUC is outside of the amniotic sac


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### Missing IUC String: Treatment

- In situ (intrauterine) placement: desires continuation
  - Leave in place for remainder of IUC lifespan
  - Option: annual pelvic ultrasound *in lieu* of string check
- Translocation (IUC in peritoneal cavity)
  - Since copper IUC may cause more adhesions, must extract promptly via operative laparoscopy
  - LNG-IUS is less reactive, but most experts recommend laparoscopic removal


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### Missing IUC String: Removal

- Pain management
  - Cervical block + oral NSAIDs for pain
  - Consider osmotic dilator or misoprostol
- Lower uterine extraction with small “alligator” forcep
  - Crochet hook best for circular IUCs; less helpful with T-shaped IUCs
  - Real time pelvic ultrasound guidance may help, if available
- If unsuccessful, suspect embedment and extract via operative hysteroscopy


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### Family PACT IUC Policy

- Both IUC products are benefits; the payment rate is equal to the acquisition cost
- To encourage counseling, an E&C visit *may* be claimed on the same day as the IUC insertion
- If the purpose of Mirena is contraceptive, it may be used in women with heavy menstrual periods
- Post-abortion IUC insertion is a covered benefit
- Covered procedures and studies for management of IUC complications must be approved by TAR


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### Family PACT IUC Policy: Purchase and Records

- IUCs must be FDA-approved devices, labeled for US use, and obtained from FDA approved distributors
- Providers must record the lot number in the med record *and* keep a written or electronic log of all IUCs inserted for at least 3 years from insertion
  - Maintain invoices  $\geq$  3 years from the date of the invoice
- Patients must be provided with a record of the dates of insertion and expiration


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### Family PACT IUC Benefit Issues

- Insertion
  - CPT 58300: Insertion of IUC
  - 58300-ZM: Insertion supplies
  - Kit: X1522 (ParaGard) or X1532 (Mirena)
  - E&C: contraceptive counseling visit
- Removal
  - CPT 58301: Removal of IUC
  - 58301-ZM: Removal supplies
  - E&C: contraceptive counseling visit


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### Family PACT IUC Complication Coverage


- All complication services *must* be approved by Treatment Authorization Request (TAR)
- Covered IUC complications
  - Vaso-vagal episode
  - Pelvic infection (secondary to IUC)
  - “Missing” IUC
  - Perforated or translocated IUC
- Consult Family PACT Policy, Procedures, and Billing Instructions (PPBI) [www.familypact.org](http://www.familypact.org)

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# Questions?

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### Family PACT Evaluation and Other Forms

At the conclusion of session complete:

1. Evaluation Form
2. Post Test
3. Continuing Education Form
4. Sign-in Sheet

Forms can be downloaded at the end of this session by file transfer.  
Those without web access can get forms by calling 1-877- FAMPACT

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