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CASE REPORT: TALE OF A MISSING COPPER-T

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ABSTRACT

Migration of Intrauterine contraceptive device (IUCD) following uterine perforation is not common, but of utmost concern. We present a case of migration of IUCD into the peritoneum after perforating the uterus and adhered to bowel and bladder.

A 23 years old lady presented with early pregnancy with IUCD *insitu*, on examination diagnosed to be misplaced copper T, laprotomy performed to recover the copper T which had embedded into the serosa of the bladder and bowel.

Keywords: intrauterine device, bladder, rectum, correct insertion, follow up.

1. Introduction

Intrauterine contraceptive device (CuT) is second most common contraception adopted worldwide since 1965 [1].

One of the most effective method of contraception worldwide.

It's easy availability and low cost makes it the most popular reversible method of contraception [2,3]. Discontinuation rate in India is 20-40% in one year [4,5,6] and reasons for the same are increased bleeding, inter menstrual bleeding, pain, pelvic inflammatory disease, IUCD expulsion, perforation of the uterus and the surrounding structures, secondary infertility, failure of IUCD leading to ectopic pregnancy.

Uterine perforation is rare and occurs at 1.6/1000 insertions[7]. As a result of perforation, the device may become embeded in uterine musculature or migrate outside uterus, commonly into peritoneal cavity, rarely into bladder or rectum[3].

2. Case Report

A 23 year old female (gravida2, parity1, living1) with previous 1 LSCS 1year 3 months back presented to the hospital with history of 1 ½ months of amennorhea and with a history of intrauterine contraceptive device (IUCD) insertion a year back. Patient had been regularly coming for follow up for the copper T thread untill 6 months, after which she had not visited the hospital.

Patient had been menstruating regularly without any dysfunction untills her last confinement. Her last menstrual date was 45 days prior to admission. There was no history of any medical co morbidities on examination. She was anxious, neither icteric, pale nor febrile. Respiratory, cardiovascular and abdominal examinations revealed no abnormalities. On per speculum examination the tail of the copper T could not be visualised. A working diagnosis of pregnancy with misplaced copper T was made. An ultrasound scan confirmed pregnancy of 6-8 weeks and copper T was seen near the myometrium and indenting on the posterior bladder wall. As the patient was scared on continuing the pregnancy, pregnancy was terminated by medical method. Patient was asked to come after 2 weeks for follow up. X ray pelvis done suggested that the copper T was projecting into the myometrium of the uterus. (fig-1). Patient was posted for hystero-laparoscopy to locate the missing copper T. To confirm that no part of the copper T was there in the cavity of uterus or bladder, hysteroscopy and cystoscopy done, findings were negative, therefore patient was posted for diagnostic laparoscopy. During laparoscopy inspite of the manipulations uterus could not be visualised and there was no sign of the device. The bladder was adherent to the colon and thus preventing us from visualising the uterus. With the help of the C-arm the copper T was located to be at the site of the adhesion, inspite of that copper T could not be identified laparoscopically hence it was decided to proceed with laparotomy. The copper T was seen embeded in between the bladder and bowel (fig-2, 3). The copper T was released from the adherent structures. The bladder serosa was closed in 2 layers and the colon serosa was closed by purse string sutures. Post procedure the patient was fine, transferred to the ward for observation. The patient was nil per oral for 3

days and gradually started on fluids and was taking normal diet after 96 hours of procedure. Antibiotics were continued for 7 days and bladder was catheterised for 14 days and she was discharged on the 15th post operative day and no complaints till date.

Figure – 1 Xray showing the copper T in pelvis

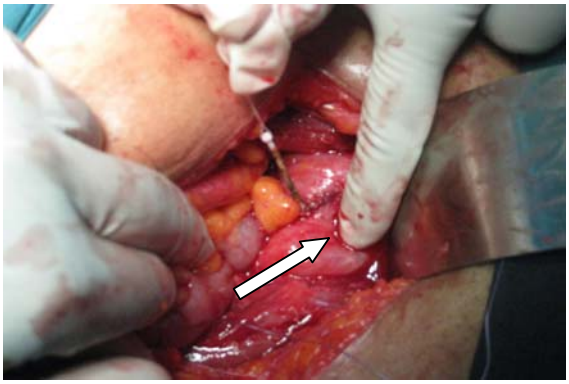

Figure – 2 Copper T embedded in the bladder.

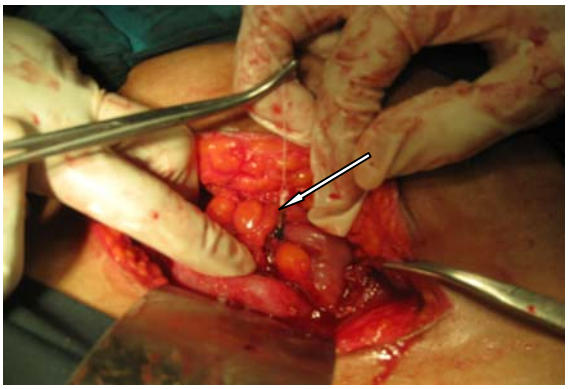

Figure – 3, Copper T in the bowel

3. Discussion

Intra uterine contraceptive device is a popular contraceptive method which is reversible and due to its low cost, low risk and high efficacy for fertility regulation it is widely accepted[2,3].

Complications associated with IUCD are dysmenorrhoea, pelvic infections, ectopic pregnancy, hypermenorrhoea,, pain, uterine perforation, migration into adjacent organs[8,9,10]. Uterine perforation by IUCD is usually at the time of insertion[11]. The technique of insertion, time of insertion, physicians skill, the uterine and cervical anatomy[9], faulty insertion technique, soft uterine wall, recent pregnancy, abortion are some of the factors which may lead to uterine perforation and subsequent transvesical migration. Patient may present with abdominal pain, voiding symptoms or may be asymptomatic. Post insertion follows up and a high index of suspicion is needed. Secondary perforation can occur by slow migration through the muscular wall of the uterus which can be augmented by spontaneous uterine contractions, urinary bladder contractions[12]. Migrated intrauterine device remain unnoticed for long and may not be discovered until it is found to be missing[13]. Persistent urinary tract infection is common presentation in case of intravesical IUCD[14,15]. Detection of intravesical IUCD by cystoscopy can be very helpful and facilitates the removal of the IUCD[16]. All migrated IUCD's must be removed. An IUCD in peritoneal cavity can cause bowel perforation, obstruction and fistula formation. Symptoms of bowel injury are fever, diarrhoea and abdominal pain. Perforation of bowel can lead to peritonitis and stricture. Presentation of symptoms of bowel perforation can take upto six months to sixteen years[17,18] . Lost device should be carefully searched using modalities like ultrasound, pelvic radiograph or computed tomography scan[15].

Prevention is the best remedy; hence correct insertion by experienced person is the mainstay. Regular follow up should be made mandatory. If in doubt ultrasound or pelvic radiograph should be done.

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