CASE REPORT

Lost and Found: A Case of Missing Intrauterine Contraceptive Device

Saudamini Naik, Amit Naik, Kalyani Muley, Sanika Choudhary

Abstract

The common presentation of patients coming with a misplaced or migrated intrauterine copper device (IUCD) is either absence of strings, or they may become pregnant, while in majority they may remain asymptomatic. In a developing country like India, contraception is treated like a national emergency. The IUCD is the commonly used contraceptive methods around the world, but it is associated with complications, which are rare. Uterine perforation is the most dreadful complication of the IUCD, which needs surgical intervention. A high degree of clinical suspicion is needed to identify it & Imaging is the best modality to diagnose the same. The IUCD can migrate or get misplaced within the peritoneal cavity either partially, or completely.

We present a case of a 36-year-old female with obstetric score of Para 3 with persistent, mild & dull aching pain in the lower abdomen. She had history of postpartum IUCD insertion five years ago followed by an abortion a year later. With the utilization of imaging modalities, the IUCD was seen on X-ray & Ultrasonography (USG). To remove the migrated IUCD an exploratory laparotomy using a small incision was done.

Keywords: Intrauterine Contraceptive Device, Contraceptive methods, Surgical intervention, X-ray.

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Introduction

In India, contraception is treated like a national emergency. The intrauterine contraceptive device (IUCD) is the commonly used contraceptive methods around the world.[1] The occurrence of complications is rare but still are reported.[2] The common presentation of patients coming with a misplaced or migrated IUCD is either absence of strings, or they may become pregnant while in majority they may remain asymptomatic. Uterine perforation is the most dreadful complication of the IUCD which needs surgical intervention.[3]

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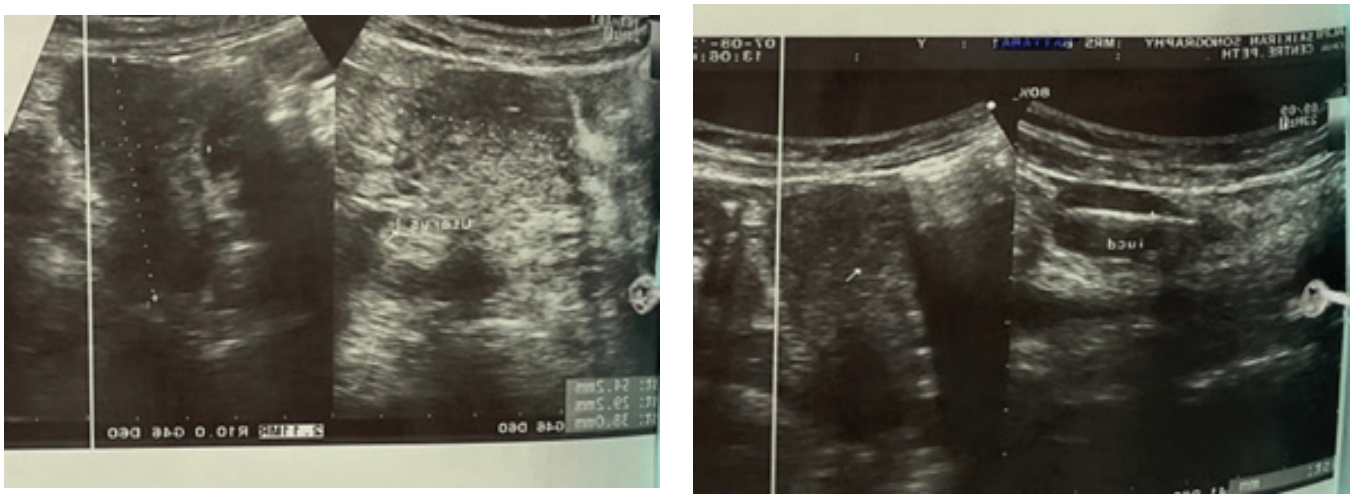

Figure 1: IUCD is seen as a linear transverse structure shown by the blue arrow.

Case Report

36-year-old female with an obstetric score Para 3 Living 3 Abortion 1, resident of Nashik presented with the complaints of pain in abdomen, which was sudden in onset and dull aching in nature. No other significant history. Her menstrual cycles were regular. She had three full term vaginal deliveries and postpartum IUCD insertion after the last delivery 5-years ago. A year thereafter, she conceived with the IUCD in-situ. She underwent medical abortion, no ultrasound was done pre and post abortion. Now, the patient was examined for her complaints & there were no obvious findings. Then, she was subjected to USG to view the abdomen & pelvis. In Figure 1, the IUCD is seen as a linear transverse structure shown by the blue arrow.

USG report stated that a Hyperechoic Linear transverse structure 2.0 x 0.5 cm noted in pelvic region just above urinary bladder with perilesional edema, mild prob tenderness noted.

X-ray erect abdomen was done which revealed linear opaque shadow at level of urinary bladder (Figure 2) (blue arrow)

Figure 2: X-ray Erect Abdomen was done which revealed Linear opaque shadow at level of Urinary Bladder.

With the diagnosis of misplaced IUCD a decision of Mini laparotomy taken. The IUCD threads were seen anterior to uterus & superior to bladder (Figure 1). Sharp & blunt dissection done & IUCD removed (Figure 2). There was evidence of healed perforation of uterus anterior to the left cornu. A cystoscopy done to assess the bladder (Figure 3). Bilateral Tubal Ligation done

With the diagnosis of misplaced IUCD a decision of Mini laparotomy taken. The IUCD threads were seen anterior

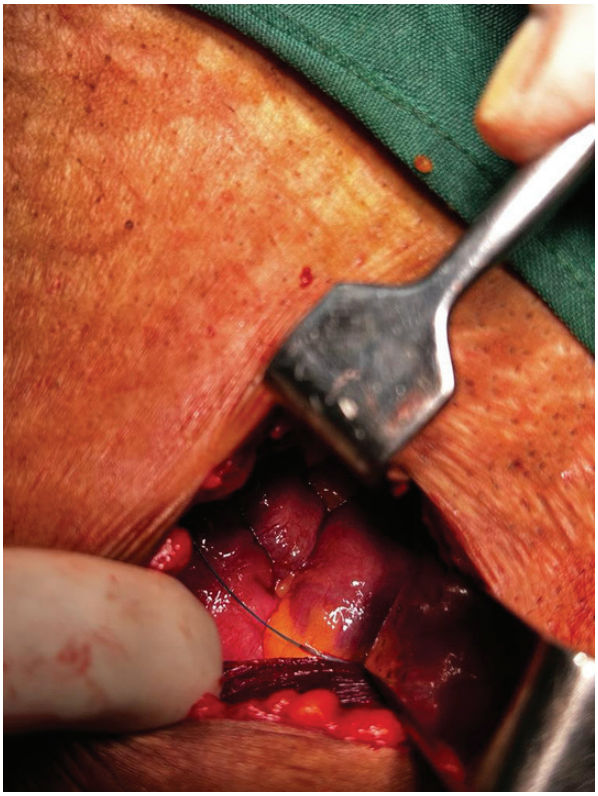

Figure 3: IUCD threads were seen anterior to uterus & superior to bladder.

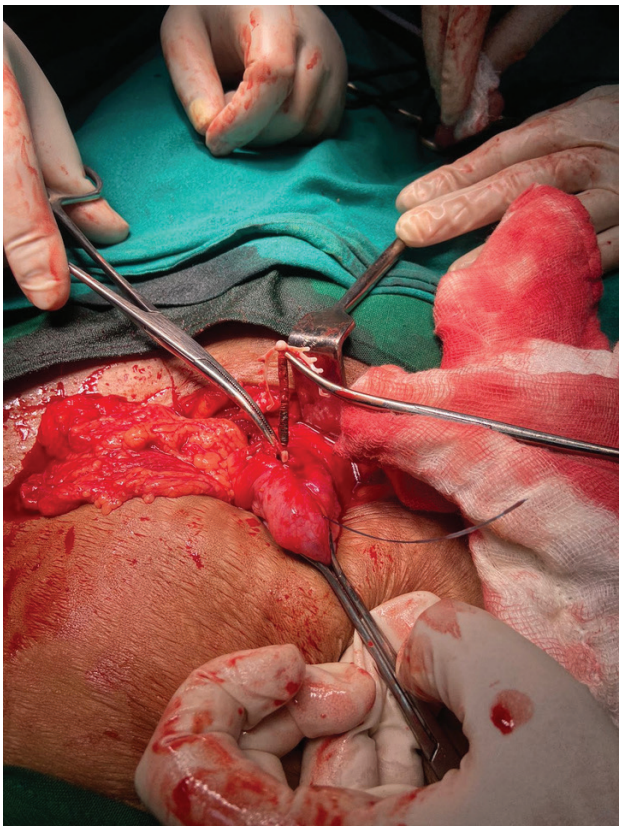

Figure 4: Sharp & blunt dissection done & IUCD removed.

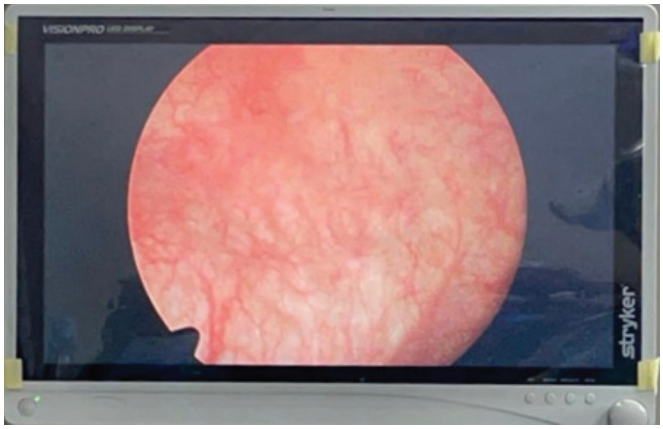

Figure 5: Cystoscopy done to assess the bladder.

to uterus & superior to bladder (Figure 3). Sharp & blunt dissection done & IUCD removed (Figure 4). There was evidence of healed perforation of uterus anterior to the left cornu. A cystoscopy done to assess the bladder (Figure 5). Bilateral Tubal Ligation done.

Discussion

Since,1965 IUCDs are being used as contraceptives.[1] The incidence of migration of IUCD is reported as 0.5–1%/1000 IUCD insertions.[2] Misplaced IUCDs are found in or near the neighbouring organs as reported by several studies.[3,4] The most common sites being the bladder as seen in our case, rectum, omentum or intestinal tract.[5,6] The most dreadful is uterine perforation which needs surgical management.[3]

The mechanism of migration of IUCD depends on the time of insertion of IUCD, the type of IUCD used, the parity, history of previous abortions, the position of the uterus or a slow erosion of the uterine wall which could be caused by chronic inflammatory reaction.[7] When the symptoms of migrated IUCD occur after a long time it is denoted as secondary migration.[1]

The initial examination of choice is a plain X-ray abdomen in lost IUCD, for finding the radioopaque IUCD in the pelvis. An ultrasonnography of the pelvis can be done to locate the position of the IUCD with respect to the uterus. The preferred treatment of the misplaced IUCD is surgical, either by laparoscopy, or laparotomy. Removal of the migrated IUCD is advisable even, if its migration has not given rise to any clinical symptoms,[8] so that, further complications like a bowel and bladder perforation or a fistula formation may be averted. Uterine perforation needs to be managed if any and in case of bladder injury a cystoscopy must which was done in our case.

Conclusion

Thus, it can be concluded that in cases of missing IUCD a high degree of clinical suspicion is necessary especially when the patient presents with pregnancy, or abortion. The important modalities to diagnose this condition are ultrasound and X-ray of the abdomen & pelvis.

Implications

Awareness regarding the regular follow up and close supervision after IUCD insertion is important to diagnose early and minimise complications.

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