

CASE REPORT

ASYMPTOMATIC MISSING INTRAUTERINE CONTRACEPTIVE DEVICE FOUND INCIDENTALLY DURING VAGINAL HYSTERECTOMY

Reena Sharma¹, Usha Kumari Chaudhary², Ajay Sharma³, Arvind Kumar⁴, Meghna Thusoo⁵

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ABSTRACT: Incidence of missing IUCD is 0.5%-2%. Usually the cause is either expulsion or perforation of uterus. Sometimes the perforated IUCD remains asymptomatic for years together and found incidentally later on. We hereby presenting a case of 55 yrs female presenting with prolapsed uterus, planned for vaginal hysterectomy. During vaginal hysterectomy asymptomatic missing IUCD was detected which was found on the anterior surface of body of uterus with omentum adherent to it.

KEYWORDS: Missing Cu T, IUCD, Omentum, Perforation.

MESH TERMS: Misplaced IUCD, Asymptomatic missing IUCD.

INTRODUCTION: Intrauterine contraceptive device (IUCD) is an acceptable contraceptive method worldwide; percentage of women using IUCD is between 5-40%.¹

Uterine perforation is a serious and rare complication, incidence of which is 1 in 350 to 1 in 2500.^{2,3}

CASE REPORT: We report here an asymptomatic patient with missing Cu-T. Patient remained asymptomatic for 25 years and Cu-T found embedded on the anterior surface of the body of uterus adherent with omentum, while doing vaginal hysterectomy.

Mrs. X, 55 years old, P₄L₄ presented in the Gynecology outpatient department with complaint of something coming out of introitus since 20 years. There was no other complaints. Patient had menopause 10 years back. In obstetrics history, patient married for 35 years, her last child birth was 25 years back and history of Cu-T insertion 3 months after the last childbirth. On one Cu-T follow up visit, she was told after examination that Cu-T threads are not visible and she might have expelled it. She was advised to undergo tubectomy. Tubectomy was done 7 years after the last childbirth.

General physical examination was normal. On local examination cervix lying 2cm outside the introitus, cervicitis+, no decubitus ulcer, cystocele+, rectocele+, no enterocele, on reposition per vaginum examination: uterus retroverted, multiparous size, firm, mobile, right adnexa thickened. The complete blood counts, renal function tests, liver function tests, serum electrolytes, chest X-ray, echocardiogram were normal. Patient was planned and prepared for vaginal hysterectomy with perineal floor repair under combined spinal epidural anaesthesia.

During intra-operative period after opening pouch of Douglas and uterovesical pouch, there was difficulty in delivering out the uterus as there was the adhesions of omentum with anterior surface of body of the uterus. On further pulling a Cu-T adherent to the omentum on anterior surface of the body of uterus was seen. Adhesions of the omentum broken and Cu-T removed en masse with uterus and cervix. Rest of the procedure completed and uterus with cervix and adherent Cu-T sent for histopathological examination.

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DISCUSSION: The prevalence of missing intrauterine contraceptive device among users is 0.5 to 2%.⁴ Missing IUCDs when Cu-T threads are not visible in vagina, as a result of expulsion or perforation of uterus (frank or occult), but occasionally there is migration of Cu-T in peritoneal cavity.⁵

Migration of Cu-T is considered due to procedure itself or a chronic inflammatory reaction with gradual erosion through the uterine wall, incidence of which depend on the timing of insertion, parity, history of previous abortions, type of IUCD, experience of operator and uterine size, position and consistency of the uterus.²

In the literature there have been reported cases of intraperitoneal IUCDs presenting with abdominal pain, pregnancies, uterine perforation with associated intraabdominal abscesses, vesical stones, appendicitis and in fact, ureteric obstruction leading to nephrectomy.⁶⁻⁸

Detection of missing IUCD could be done by ultrasonography, pelvic- abdominal radiography, laparoscopy and hysteroscopy.^{3,5,9} Ultrasonography is unreliable if Cu-T device is surrounded by omentum or loops of bowel.¹⁰

Commonly seen symptoms by displaced Cu-T include abdominal pain and menorrhagia but asymptomatic patients with silent perforations have been reported.

Management of extrauterine displaced Cu-T is controversial, but all Cu-T devices should be removed electively as soon as detected to avoid complications like damage to adjacent organs, adhesions, bowel obstruction and medico legal problems.

CONCLUSION: In our country, fertility control is the need of the hour. Our aim should be to bring down the failure and complication rates of these methods for increasing the acceptance of contraceptive methods. Cu-T is a safe and cheap method of contraception so we should take all the precautions to avoid such complications. The woman should be educated to check for the threads periodically and report immediately in case of non localisation. If a woman does not observe the expulsion of Cu-T device and there is missing thread on follow up, then it should be considered as extrauterine translocation until contrary is proved.

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Fig. 1: Showing Cu-T embedded on body of uterus adherent to omentum



Fig. 2: Showing Cu-T embedded in the body of uterus

AUTHORS:

1. Reena Sharma
2. Usha Kumari Chaudhary
3. Ajay Sharma
4. Arvind Kumar
5. Meghna Thusoo

PARTICULARS OF CONTRIBUTORS:

1. Senior Resident, Department of Obstetrics & Gynaecology, Dr. RPGMC, Tanda, Kangra, H. P.
2. Senior Resident, Department of Anaesthesia, Dr. RPGMC, Tanda, Kangra, H. P.
3. Senior Resident, Department of Cardiology, Dr. RPGMC, Tanda, Kangra, H. P.

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4. Junior Resident, Department of Pharmacology, Dr. RPGMC, Tanda, Kangra, H. P.
5. Senior Resident, Department of Obstetrics & Gynaecology, Dr. RPGMC, Tanda, Kangra, H. P.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Usha Kumari Chaudhary,
Senior Resident,
Department of Anaesthesia,
Dr. RPGMC, Tanda,
Kangra, H. P, India.
E-mail: chaudhary.ushaarvind@gmail.com

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