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Finding its way out on its own - the story of a misplaced IUCD

Amirdhasena S
Department of Obstetrics and Gynaecology, Madras Medical College and Government General Hospital

Abstract : Misplaced IUCD is defined as the condition when the tail of the IUCD is not seen through the os. The presentation varies widely and a high index of suspicion is required for diagnosis. This is a 26 years old patient who underwent emergency repeat caesarean section with post placental IUCD insertion 6 months ago. She had gestational diabetes requiring insulin antenatally and had postoperative wound infection. The patient was not on regular follow up and presented 6 months later with complaints of serous discharge from the wound site for past 5 months and complaints of pain over the lower abdomen for the past few days. One week later she developed a discharging sinus infraumbilically. IUCD tail was not seen and on further evaluation IUCD was found to perforate the anterior uterine wall. Laparoscopy was not done as patient was found to have dense abdominal adhesions during caesarean section. On laparotomy, uterus was adherent to the anterior abdominal wall, tip of IUCD was seen perforating through the fundus on the left side with bowel adhesions. The same released and IUCD removed. This case reflects the importance of follow up post IUCD insertion and the need to evaluate for misplaced IUCD when tail is not visualised. Also, the discharging sinus in this case provided a valuable clue without which this patient may have been treated for chronic wound infection alone.

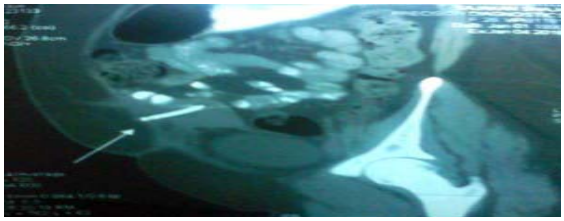
Keyword : Misplaced, IUCD, Perforation, Adhesions, Sinus

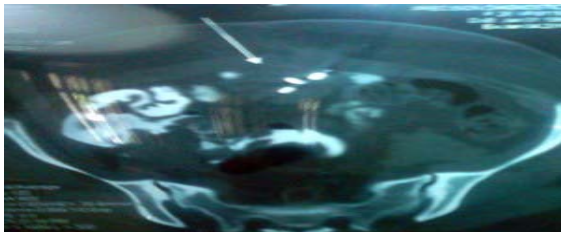
INTRODUCTION

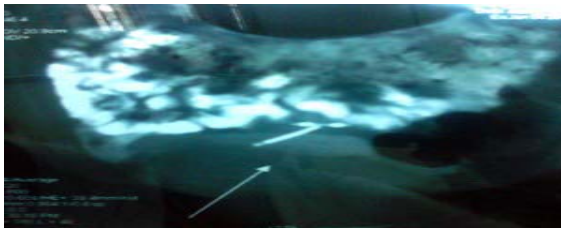
Intra uterine contraceptive device is a very acceptable and widely used contraceptive in India. Post placental insertion of IUCD is gradually increasing, being convenient for health care providers as well as their clients. Adequate counselling will ensure proper follow up post insertion. Good follow up care results in client satisfaction and continuation of this method. It also helps in making IUCD a much sought after contraceptive especially for birth spacing.

CASE REPORT

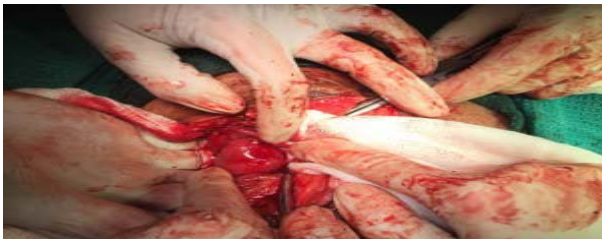
A 26 years old P2L2 woman who underwent emergency repeat caesarean section with post placental IUCD insertion 6 months ago came to the op with complaints of serous discharge from the LSCS wound site for the past 5 months, associated with pain over the lower abdomen for the past few days. Patient was still in lactational amenorrhoea. On examination, the skin over the lower abdomen was indurated with purulent discharge from the LSCS wound site. After few days, she developed a sinus tract with purulent discharge from the indurated region infraumbilically. On per vaginal examination, IUCD tail could not be felt and the cervix was drawn up. Plain X ray abdomen was taken - misplaced IUCD found. Ultrasound abdomen showed CuT perforating the fundus of the uterus into the posterior aspect of the anterior abdominal wall just below the level of umbilicus.







CT, though not the initial imaging study of choice for misplaced IUCD, was done to plan surgery. It showed anteverted uterus with the fundus reaching up to the posterior aspect of the infraumbilical anterior abdominal wall. IUCD was seen to perforate through the fundus of the uterus. Two linear radiolucencies were seen extending from the region of IUCD through the anterior abdominal wall to the skin surface, suggestive of displaced IUCD with discharging sinus. As the patient had dense adhesions during caesarean section, laparotomy was preferred. Intra operatively, uterus was drawn up, adherent to the anterior abdominal wall. Horizontal limb of CuT 380A was seen perforating the fundus of the uterus on the left side, with small bowel adhesions. The same released, IUCD removed with forceps and the sinus tract excised. Postoperative period was uneventful.



DISCUSSION

The incidence of perforation following IUCD insertion is 1-3 per thousand. The perforation may be primary, occurring at the time of insertion or it can occur later, aided by uterine involution and relatively high intrauterine pressure. Migration occurs subsequent to perforation. If IUCD extends through the serosa but still partially contained in the uterus, as in this case, the most common complication is omental adhesion formation. Caesarean insertion has significantly fewer complications than vaginal insertion. Perforation following caesarean section is rare. WHO recommends that regardless of the type of the insertion and location, perforated IUCD has to be removed. In this case, the women had uncontrolled GDM at the time of her caesarean section. Also, during emergency caesarean, uterus was found to be plastered with the anterior abdominal wall, hence uterine incision made in the upper segment to deliver the baby. These factors might have lead to chronic infection and poor healing which could have contributed to perforation and migration of the IUCD, the problem being compounded by poor patient follow up.

CONCLUSION

Mere IUCD insertion should not be the end point of family planning services. Women should be educated about the need for regular examination and follow up. Early identification and management of misplaced IUCD will help in reducing the morbidity.

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