Bangladesh J Obstet Gynaecol, 2024; Vol. 39(2): 117-119

Case Reports

Migration of CuT380A, A Case Report

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Abstract

Background: *Intrauterine contraceptive devices (IUCD) is an effective, reversible long term contraceptive method. Uterine perforation is one of the rare & most significant complication of IUCD which commonly occurs during primary insertion rather than presenting as delayed migration. This is a case of migrated IUCD into the left iliac fossa of abdomen wrapped in the omentum, diagnosed incidentally due to abdominal pain. IUCD was retrieved successfully by laparoscopic approach. So, regular follow up plays crucial role to diagnose early complication.*

Case report: *A 18 years old girl P-1 (VD), ALC -14 months, was admitted to Gynae department of ShSMCH with a history of lower abdominal pain for 2 months & incidental diagnosis of extra-uterine IUCD. It was inserted 45th day of postpartum. After insertion she was regularly menstruating with average flow & duration. But she developed continuous dull aching abdominal pain for last two months then visited to a local doctors. USG & X-ray of abdomen revealed extra-uterine IUCD in left iliac fossa. Hence she was referred to ShSMCH for retrieval. On examination her general condition was good & abdomen was soft but mild tenderness over the left iliac region. On laparoscopy CuT along with omentum embeded to left side of the parital wall which was removed after adhesiolysis while small amount of pus come out.*

Discussion: *IUCD migration has a great impact on patient physical & mental health. WHO recommends surgical removal of the migrated IUCD by minimally invasive method. Follow up after insertion is crucial for early diagnosis of migration.*

Conclusion: *All migrated IUCD must be removed as it can cause bowel & bladder perforation, fistula formation. Missing CuT- 380A can be diagnosed by USG, X-ray, CT scan. Our case was detected by USG & X-ray. Removal by laparo-hysteroscopy is best approach depending upon location.*

Introduction

IUCD is preferred method used by 14.3% of modern contraception users globally[1]. It is an effective, reversible, long term method of contraception. Although IUCD has been proven to be a safer contraception for many women like other birth control methods but there might be some potential side effects or complications. Some common complication include PID, IUCD expulsion, IUCD retraction into the cervix or uterus & uterine perforation[2]. Most studies suggest that perforation occur between 0.3 - 2.6 per 1000 insertion. IUCD migration is a rare but serious complication that occur after insertion, sometimes year's later[3]. Many patient with trans- located IUCD are asymptomatic, present with pregnancy or missing strings[3], 80% of IUCDS are found on the peritoneal cavity after perforation. Migration into surrounding structure is rare but serious complication[4].

Factors related to perforation include design of device, patient characteristics such as uterine size and position and timing of insertion related to delivery or abortion. Uterine perforation occurs mostly during insertion and may cause pelvic pain, bleeding from the rectum or vagina. If unrecognized, fibrosis and adhesion formation can occur. Bowel perforation can lead to abscess formation, intestinal ischemia or volvulus[2].

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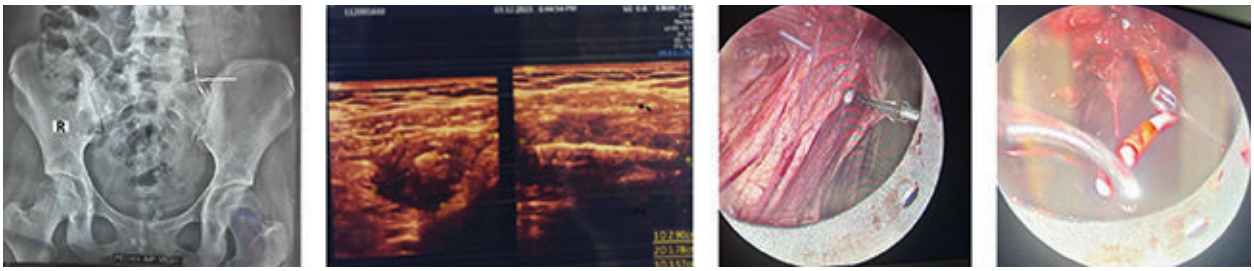

X- ray of Pelvis *USG view* *Laparoscopic View* *Retrival of Cu-380A*

Figure-1:

Here we report a case of intraperitoneal IUCD migration into the pelvic wall diagnosed incidentally by USG & X-ray due to abdominal pain which was removed successfully by laparoscopy. As migration of IUCD is one of the rarest complication so we hope this reporting will help others to have an exposure to such an event and to know the safest way of retrieval.

Case Report:

A 18 yrs old girl P-1 with vaginal delivery came to Gynae indoor with history of lower abdominal pain for 2 months & incidental diagnosis of extra uterine IUCD which was inserted at her 45th day of puerperium. Age of last child is 14 months. After insertion her cycle was regular with average flow & duration. Later she complaints of lower abdominal pain for last two months then visited a local doctor one month back & USG showed missing IUCD, X-ray of pelvis revealed Cu-T in left iliac fossa hence she was referred to ShSMCH for proper management. On examination her general condition was good, vital sign was normal, abdomen was soft, mild tender over the left iliac region. On speculum examination thread of IUCD not visible & uterus was normal size fornices were free & non tender. On repeat USG show no Cu-T seen inside the uterus, linear echogenic structure with surrounding hyper-echoic lesion measure about 2.9 x 1.7 cm x 3.5 cm is seen in left iliac fossa. Laparoscopy was done & Cu-T 380A found wrapped with omentum embeded in left iliac region abdominal wall and successively removed after adhesiolysis.

Procedure

In this case IUCD was removed successfully by laparoscopic procedure. Uterus, both fallopian tube, ovary was normal & healthy. Cu-T along with omentum was adherent on the left anterior abdominal wall at iliac region where tip of the Cu-T was visible through the adhesion. Omentum was separated from abdominal wall then tip of the embedded Cu-T was grasped with meriland forceps & gradually released from the abdominal wall, scanty amount of pus came out & washed with normal saline, haemostasis achieved. Whole abdominal cavity was searched for injury. The patient was kept NPO for 6 hours & was discharged on 1st POD without any complication.

Discussion:

IUCD is one of the safest long term contraceptive devices used by women ranges from 14 to 27% worldwide. Most of the women insert IUCD in lactation period while the uterus is soft. Early puerperial IUCD was found to be a risk factor of migrated IUCD. It is one of the rare complication & can often be asymptomatic.[6]

IUD migration can be classified into three types (i) partial migration- here IUD embedded into myometrium; (ii) Complete migration in which IUD completed embedded in myometrium, (iii) Migrated completely outside the uterus in which IUD leaves the uterine cavity & enters into the pelvic cavity or other areas of abdominal cavity[2]. can be localized in various neighboring organ with ectopic localization in omentum, mesentry, pouch of doglous, colon & bladder have been reported. Clinical presentation varies depending on site of migration & type of IUCD.

In this case IUCD inserted at 45 days of puerperial period following her vaginal delivery. Now after 10 months of insertion patient complaints of continuous dull aching lower abdominal pain around the left illiac fossa but bowel & bladder habit is normal. Clinically there was no string is visible on speculum investigation & USG show empty uterine cavity & linear echogenic structure with surrounding hyperechoic lesion in left iliac fossa.

The clinical diagnosis is not always obvious, and aid of radiological imaging are necessary to locate the device, including ultrasound, X-ray, CT scan or

Magnetic Resonance Imaging[5]. WHO recommends surgical removal of migrated IUCD by minimally invasive methods, including hysteroscopy, cystoscopy, colonoscopy, or laparoscopy, depending on the location[5]. However laparotomy may be done but it was difficult to find out inside the peritoneal cavity. In this case laparoscopy done to retrival of IUCD & it is found wrapped with omentum over the left parital wall of abdomen & retrived safely after adhesiolysis.

Finally regular follow up is important to diagnose the migration at its earliest, thereby to avoid the adverse effects & complications of migrated IUCD.

Conclusion:

Correct time of insertion is utmost important to avoid IUCD complications. Moreover placement should be done by an experienced hand. Regular follow up is important to prevent complication like migrated IUCD. Endoscopic approach are the best for retrieval of migrated IUCD.

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