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Case Report

Incidental discovery of a copper-migrated intrauterine device in the rectum during abdominal hysterectomy

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ABSTRACT

The objective of the study is to report a case of IUDs migrating into the rectum that were accidentally discovered during an abdominal hysterectomy. This was a 47-year-old G9P8 patient with eight live vaginal births and one abortion dating back 7 years. As management, she would have received intrauterine suctioning followed by IUD insertion. The diagnosis of IUD migration was made during an abdominal hysterectomy for high grade cervical dysplasia CIN2. The migrating IUD perforated the right end of the posterior aspect of the uterine isthmus and the anterior aspect of the upper rectum. It was removed using forceps with its "T" that was lodged in the uterine wall and its body and thread in the rectum. The rectal breach was sutured with vicryl and total hysterectomy with bilateral adnexectomy could be performed without any other particularities. Migration of a copper IUD into the rectum is exceptional. However, it should be considered in a patient with digestive disorders in the days following the insertion of an IUD. The absence of the son should be a warning, and imaging and especially the digestive endoscopy allow the diagnosis to be made and at the same time its extraction to be carried out as soon as possible.

Keywords: Migration, Intrauterine device, Contraception

INTRODUCTION

Intrauterine contraceptive devices (IUD) account for 23% of general use of reversible contraceptive measures worldwide.[1] Uterine perforation with an IUD is a rare complication, estimated at 0.5-1/1,000 insertions.[2] Several migrant IUD locations are described. However, rectal localization remains exceptional and poses diagnostic and therapeutic problems.[3]

Thus, we report a case of IUD migration in the rectum discovered incidentally during laparotomy for hysterectomy in a 47-year-old patient.

CASE REPORT

This was a 47-year-old G9P8 patient with eight live vaginal births and one abortion dating back 7 years. As management, she would have received intrauterine suctioning followed by IUD insertion. The discovery of the migrant IUD was made during a hysterectomy laparotomy indicated for high grade CIN2 cervical dysplasia. At the time of posterior dissection, the migrant IUD was found at the right end of the posterior surface at the level of the uterine isthmus. The IUD had perforated the uterine isthmus and the anterior aspect of the upper rectum (Figure 1A). Extraction of the IUD (Figure 1D) was performed using forceps with its "T" (Figure 1B) that

was lodged in the uterine wall and its body and thread in the rectum (Figure 1C).

The rectal breach was sutured with Vicryl and total hysterectomy with bilateral adnexectomy was continued without further procedure and the surgical specimen (Figure 2) was sent for histology.

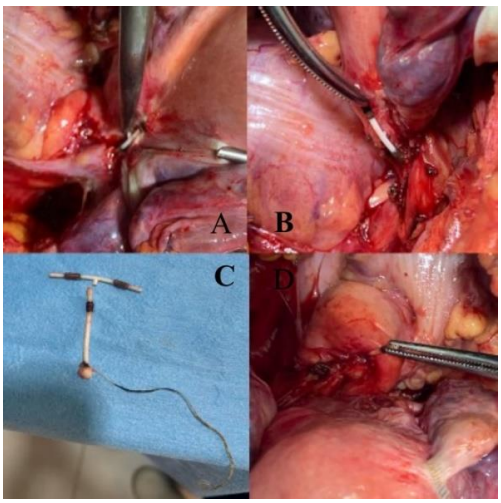

Figure 1 (A-D): Migrating IUD in the rectum.

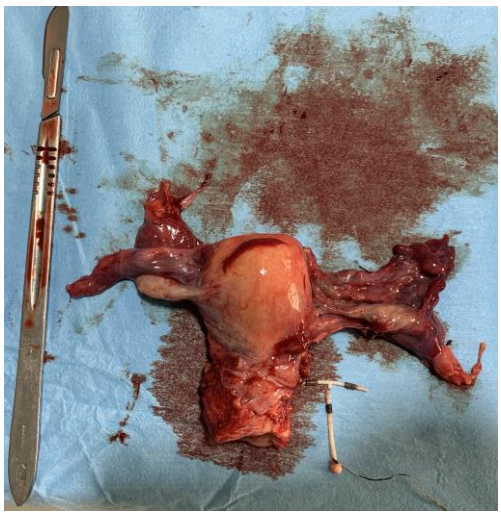

Figure 2: Surgical specimen.

In the aftermath, interrogation found a notion of intense abdominal pain after the IUD insertion that had motivated repeated consultations with a prescription for analgesics as treatment. However, the patient never presented with rectal problems.

DISCUSSION

The copper-bearing intrauterine device is an effective and well-tolerated long-term contraceptive method that requires a trained provider for insertion.[4] However, complications are possible, including uterine perforation, with migration of the IUD being the most serious complication.[5] Fortunately, it remains a rare complication, estimated at 0.5-1/1,000 insertions.[2] Some risk factors have been described such as lack of experience, a retroverted uterus, or the presence of a defect in the myometrium.[6] Migrant IUD have been found in all quadrants of the abdomen, particularly in the Douglas, the broad ligament and the omentum.[7] The rectal location of the IUD involves particular diagnostic and therapeutic problems and leads to very diverse clinical situations. As a general rule, the migration of a foreign body into a hollow organ is progressive and, in most cases, complete.[3] The disappearance of the IUD sutures during the clinical examination of the patient should always suggest uterine perforation. The presence of symptoms such as tenesmus, rectal rectorrhagia, false cravings, or abscess of the rectum, as well as clinical examination with the vaginal and rectal examination, allow suspicion of involvement of the rectal wall or subperitoneal lateral pelvic spaces if the IUD is accessible with the finger. Ultrasound and a PSA allow in most cases to visualize the position of the migrating IUD. A CT scan may be necessary if previous examinations do not reveal the position of the IUD.[3] In our case, the clinical picture was rather discreet apart from the abdominal pain that our patient presented after the IUD insertion. A pelvic ultrasound was done, but the IUD was not revealed. Classically, removal of a migrating IUD is performed laparoscopically.[8] The particularity of the management of an IUD that has migrated to the rectum is that endoscopic examinations are associated with surgical management. Any clinical or radiological suspicion of rectal damage must indeed be investigated by rectoscopy. If laparoscopy is initially performed and reveals rectal damage by a migrating IUD, a rectoscopy must be performed simultaneously in order to reveal damage to the rectal mucosa. If the rectal mucosa is intact, the IUD can then be removed by laparoscopy alone. If the rectal wall is penetrated and a branch of an IUD is inserted into the rectal lumen, the IUD can be removed rectally to limit contamination of the peritoneal cavity and thus the risk of pelvic abscess or postoperative peritonitis. A blue test will complete the removal of the IUD and, if positive, a transparietal suture will then be performed laparoscopically.[3] In our case, the discovery of the migrant IUD was made during a laparotomy and at the same time its removal was performed. In fact, 85% of reported perforation cases do not cause complications and remain asymptomatic until diagnosis.[9]

CONCLUSION

The migration of a copper IUD into the rectum is exceptional. However, this should be considered in a patient with digestive problems in the days following the insertion of an IUD. The absence of the son should be a warning, and the imaging and especially the digestive endoscopy will allow the diagnosis to be made and at the same time allow its extraction to be carried out, which must be done as soon as possible.

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