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Case Series

Retained and forgotten intrauterine contraceptive devices: a case series from Kasturba Hospital, Delhi

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ABSTRACT

Intrauterine contraceptive devices (IUCDs) are widely used for long-acting reversible contraception. Rarely, devices may be retained, forgotten, or only discovered incidentally years later, presenting diagnostic and management challenges. We report four women who presented to the outpatient department of Kasturba Hospital, Delhi with retained or missing IUCDs. Presentations ranged from symptomatic postmenopausal bleeding and pelvic pain to incidental discovery in surgical specimens. Imaging and removal strategies varied according to clinical scenario. These cases underscore the importance of thorough history, targeted imaging, documentation of IUCD insertion, and patient education to prevent prolonged unnoticed retention. They highlight diagnostic pitfalls and management dilemmas in both symptomatic and asymptomatic retained devices.

Keywords: IUCD, Forgotten IUD, Retention, Hysteroscopy, Postmenopausal IUCD

INTRODUCTION

Intrauterine contraceptive devices (IUCDs) are among the most effective long-acting reversible contraceptive methods worldwide, with high continuation rates and proven safety.[1,2] Despite their widespread use, complications such as expulsion, malposition, missing strings, uterine perforation, and migration have been reported.[1-3] Missing or retained IUCDs pose diagnostic challenges and may remain undetected for prolonged periods, especially when inserted decades earlier or when adequate documentation and follow-up are lacking.[4,5]

Forgotten IUCDs are more commonly encountered with older inert devices such as Lippes loop and multiload, which were widely used in earlier decades.[4-6] These devices may remain asymptomatic or present with nonspecific symptoms such as pelvic pain, abnormal uterine bleeding, foul-smelling discharge, or be discovered incidentally during imaging or surgery.[5,7] Ultrasonography is the preferred first-line modality for localization of missing IUCDs, although its sensitivity may be limited in cases of uterine pathology or device embedment.[7,10] Hysteroscopy is considered the gold standard for removal of retained IUCDs when outpatient methods fail.[8,9]

This case series describes four women presenting to the gynaecology outpatient Department of Kasturba Hospital with missing or forgotten IUCDs, highlighting varied presentations, diagnostic limitations, and management approaches.

CASE SERIES

This is a retrospective descriptive case series conducted at Kasturba Hospital, Delhi. The series includes four women with retained or forgotten IUCDs identified over different time periods. Three cases were discovered incidentally during routine clinical evaluation or surgical procedures performed for unrelated gynecological indications, while one case was identified during evaluation for symptoms.

Data were collected retrospectively from medical records, operative notes, imaging reports, and histopathology findings. No additional investigations or interventions were performed specifically for the purpose of this study. Patient identifiers were removed, and only anonymized clinical information was used for analysis and reporting.

Case 1

A 65-year-old woman, G2P2, postmenopausal for 18 years, presented with foul-smelling, blood-stained vaginal discharge and lower abdominal pain for three months. She had never used contraception and had no recollection of any IUD insertion. Ultrasonography performed earlier showed only postmenopausal atrophic changes. At presentation, per-speculum examination revealed an atrophic cervix and a fine nylon thread protruding through the external os, suggestive of an IUD string. Repeat sonography, performed with specific attention to the possibility of a retained device, confirmed an intrauterine Lippes loop.

Further history revealed that 44 years earlier, after her second delivery, she had visited a government hospital for abdominal pain. She recalled being examined in a separate room before seeing the consultant, during which an IUD was likely inserted without her knowledge. Under anaesthesia, attempts to remove the IUD by traction on the thread failed, and the thread eventually broke. Curved artery forceps was introduced blindly into the uterine cavity, and the Lippes loop was successfully retrieved. Endometrial curetting's and Pap smear showed no malignancy (Figure 1).

Figure 1: Forgotten Lippes loop being removed.

Case 2

A 46-year-old woman, P5L5, presented with persistent lower abdominal pain and heavy menstrual bleeding for 5–6 months (6–8 pads/day), associated with clots and dysmenorrhea. She denied any history of IUD insertion.

Ultrasonography revealed a bulky uterus (5.0×11.2 cm) with multiple intramurals and subserosal fibroids (largest 3.0×3.7 cm) and an atrophic endometrium. No foreign body was identified. Medical management offered temporary relief, and endometrial biopsy revealed benign tissue. Due to persistent symptoms and the presence of fibroids, a total abdominal hysterectomy was performed.

Unexpectedly, macroscopic examination of the hysterectomy specimen revealed a multiload IUD embedded in the uterine cavity, surrounded by atrophic endometrium and fibroids. There was no evidence of perforation, migration or infection. The device had remained unnoticed for decades despite multiple clinical encounters and imaging (Figures 2 and 3).

Figure 2: Retrieved Lippes loop.

Figure 3: Macroscopic examination of the hysterectomy specimen revealed a multiload IUD embedded in the uterine cavity.

Case 3

A 63-year-old postmenopausal woman (menopause in 2018), P2L2A1, presented for removal of an IUCD inserted in 2014 (Cu-T 380A). She had a history of two prior IUD insertions in 1999 and 2004 (multiload devices). She was asymptomatic.

On examination, IUD strings were visible. Outpatient removal was attempted, but traction met resistance. Transvaginal sonography showed vertical arm of the IUD at the fundus, horizontal arms folded upward along the vertical arm (suggestive of deformation) and no fluid or

mass in cavity. Given the failure of multiple removal attempts and her refusal of hysteroscopic retrieval, she was advised to leave the device in situ with routine follow-up and to report any pelvic pain or postmenopausal bleeding (Figure 4).

Figure 4: Asymptomatic Intrauterine IUCD for 12 years.

Case 4

A 40-year-old multiparous woman, P9L5, presented with fourth degree uterine prolapse. Her last child birth was 12 years back, which was a normal vaginal delivery. She was postmenopausal for one and half years. Her vaginal hysterectomy with colpoperineorrhaphy was planned. During vaginal hysterectomy, an IUCD was incidentally discovered in the uterine specimen. On enquiry she confirmed IUCD insertion done more than 10 years back but couldn't recall the exact time of insertion and apparently had no problem with it.

On broad inspection, the retrieved IUD was a Cu 380 IUCD which showed absence of copper on the vertical limb, consistent with prolonged residence (Figures 5 and 6).

Figure 5: Macroscopic examination of uterus revealed a Cu IUD 380 A.

Figure 6: Retrieved IUCD with no copper on vertical limb indicating prolonged retention.

Table 1: Demographic and clinical profile of patients with retained/missing IUCDs.

Case no.	Age (years)	Parity	Menopausal status (years)	Presenting complaint	Estimated duration of IUCD retention
1	65	P2L2A0	Postmenopausal 18	Foul-smelling blood-stained discharge, pelvic pain	44 years
2	46	P5L5A0	Premenopausal	Heavy menstrual bleeding, dysmenorrhea, pelvic pain	Unknown (likely decades)
3	63	P2L2A1	Postmenopausal 10	Asymptomatic; request for IUCD removal	10 years
4	40	P9L5A0	Postmenopausal 1.5	4° uterine prolapse	More than 10 years

Table 2: IUCD characteristics and diagnostic findings.

Case no.	Type of IUCD	String visibility	Imaging finding	Mode of detection
1	Lippes's loop	Yes (initially)	IUCD visualized on repeat focused USG	Speculum exam + USG
2	Multiload	No	Not detected on preoperative USG	Incidental during hysterectomy
3	Cu – 380 A	Yes	Deformed IUCD, folded horizontal arms	TVS
4	Cu – 380 A	No	Not suspected preoperatively	Incidental during vaginal hysterectomy

Table 3: Management strategies and outcomes.

Case no.	Management	Removal method	Complications	Outcome
1	Surgical	Blind retrieval under anesthesia	None	Successful removal
2	Definitive surgery	Total abdominal hysterectomy	None	Incidental IUCD removal
3	Conservative	IUCD left in situ	None	On follow-up
4	Surgical	Vaginal hysterectomy	None	IUCD removed with specimen

Observations

Four cases of retained or forgotten IUCDs were identified. The demographic profile, presenting complaints, diagnostic findings, management strategies, and outcomes are summarized in Tables 1-3.

DISCUSSION

The findings summarized in Tables 1-3 highlight the heterogeneity in presentation, duration of retention, and management of forgotten IUCDs. Two devices were detected incidentally during hysterectomy, emphasizing the limitation of routine imaging and the importance of clinical vigilance. Older inert devices such as Lippes loop and multiload were associated with prolonged unnoticed retention, consistent with existing literature.

Retained or forgotten IUCDs represent an uncommon but clinically relevant issue, often resulting from poor follow-up, inadequate counseling, or lack of patient awareness regarding device insertion and removal timelines.[1,2] In our series, two IUCDs were detected incidentally during hysterectomy, emphasizing the possibility of prolonged asymptomatic retention.

Postmenopausal women with retained IUCDs may present with abnormal bleeding, pelvic pain, pyometra, or infection, although many remain asymptomatic.[4,5] There is no strong evidence linking retained IUCDs to endometrial malignancy; however, evaluation to exclude pathology is recommended, especially in postmenopausal bleeding.[5,15]

The absence of visible strings is a common presentation of missing IUCDs and should prompt imaging to confirm intrauterine location and exclude migration or perforation.[9,10] Transvaginal ultrasonography remains the initial modality of choice, but plain radiography or advanced imaging may be required when localization is uncertain.[10,11]

In case 1, blind retrieval under anesthesia was successful, whereas case 3 demonstrated deformation and embedment of the device, making removal difficult. Hysteroscopic removal has been shown to be safe and effective in such scenarios, reducing the need for more invasive procedures.[8]

Expectant management may be considered in asymptomatic postmenopausal women who decline intervention, as seen in case 3, provided close follow-up and patient counseling are ensured.[9,15]

These cases highlight the importance of proper documentation at insertion, patient education, routine follow-up, and timely removal of IUCDs to prevent prolonged unnoticed retention and its potential complications.[1,2,9]

Patient education on duration of use, symptom vigilant monitoring, and timely removal is critical to prevent similar cases.

CONCLUSION

Retained IUCDs can remain undiagnosed for decades and present variably, from symptomatic complaints to incidental surgical findings. Thorough history taking, targeted imaging, patient education, and careful documentation at insertion are essential to prevent prolonged retention. Clinicians should maintain a high index of suspicion in women with missing strings or unexplained pelvic complaints.

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