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Case Report

A case report of successful retrieval of missing Cu T from peritoneal cavity in a case of pelvic Tuberculosis

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ABSTRACT

The 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 and found incidentally later. We are hereby presenting a case of 35 years female P3 L3 who had Cu T insertion 3 years back. She was asymptomatic for more than 2 and ½ years and then presented with severe pain abdomen for which she was evaluated and exploratory laparotomy was done and Cu T was found embedded in the serosa of rectosigmoid colon which was covered by dense omental adhesions.

Keywords: IUCD, Laprotomy, Missing CuT, Perforation

INTRODUCTION

Intrauterine contraceptive device is an acceptable contraceptive method worldwide. IUCD is safe, effective and a low-cost method when used as contraception and hence is widely used in developing countries.[1] One of the reasons for discontinuation rates of 20-40% is the fear of complications such as excessive bleeding, pain, infection, uterine perforation and spontaneous expulsion.[2] Uterine perforation is one such complication which is rare and occurs in 0.5/1000 insertions. However, it has a potential risk and is often silent. Health workers need to be aware of this complication and should take necessary precautions while inserting Copper T and be able to provide prompt diagnosis and treatment in the case of missing IUCD so as to prevent chances of migration of IUCD and prevent bowel and bladder perforation.[3]

CASE REPORT

A 35 years old female, P3L3 came to Gynae OPD with complaint of missing thread of Cu T since 1 and ½ years and severe pain in abdomen for 3 months.

She had previous all full term normal vaginal delivery and her last child birth was 3 and ½ years back and Cu T was inserted 6 months after last child birth by a health worker in periphery. She did not have any major complaint after insertion. She had regular menses after insertion, bleeding was slightly excessive lasting for 5-6 days with passage of few clots. However, she did not have any regular follow up of Cu T. Her 1st follow up visit was after 1 and ½ years of insertion by health worker in periphery and according to patient Cu T thread was visible at that time during examination.1 year later she started having complaint of severe pain in lower abdomen which was dull in nature at times colicky which aggravated during menses for which she consulted a local doctor where Cu T thread was not visible and she was investigated and USG was done in which Cu T was not visible in endometrial cavity. X-ray pelvis was done which showed Cu T in right Iliac fossa and hence she was referred to our hospital for further management.

On examination patient was of average built, her BMI was 17.7, there was mild Pallor. Other vitals were normal. Abdomen was soft with mild tenderness in right

Iliac fossa on deep palpation. On Speculum examination Cu T thread was not visible, cervix was hypertrophied, congested and slight discharge was present. On per vaginal examination uterus was anteverted, normal size mild tenderness was present, fornices was free, Cu T thread was not felt.

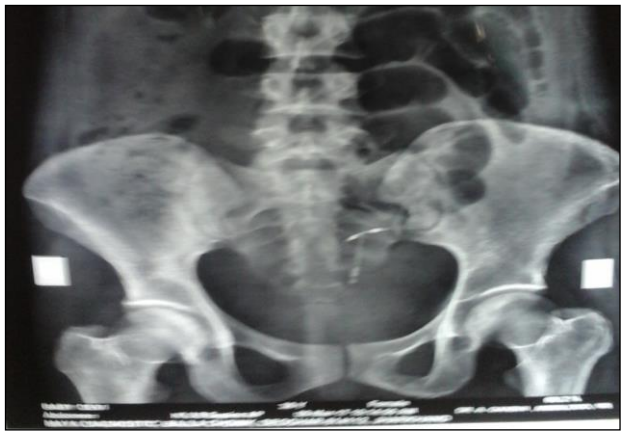

Figure 1: X-ray pelvis showing misplaced Cu T.

Patient was admitted for further evaluation. Routine investigations: Hb 7.5 g/dl, ESR was raised 132, S.TSH 8.9 and blood sugar F - 112, PP - 191, HBA1C - 4.8%. CA 125-99.4.

She was given one-unit whole blood transfusion and Tab Thyroxine 50 µg was started, she was put on diabetic diet and CECT whole abdomen and pelvis was done which showed IUCD related uterine perforation with collection in right adnexal region and matted bowel loops.

After building up her Hemoglobin and after achieving euglycemic status she was posted for exploratory laparotomy with suspicion of pelvic tuberculosis.

Procedure

During surgery, there were dense adhesions between anterior abdominal wall and peritoneum and bowel which was separated by blunt and sharp dissection. Bowel loops were matted and dense omental adhesions was present. Adhesions released by blunt and sharp dissection and CuT was found embedded between omental adhesions on posterior surface of uterus on right side and serosa of rectosigmoid colon. Cu T was removed.

Small serosal injury present in bowel which was repaired. Hemostasis secured. Due to dense adhesions, tubal ligation was not possible and husband was counseled for vasectomy. Peritoneal washings taken and sent for cytochemical analysis. Patient was kept Nil per oral for 72 hours. Her postop period was uneventful. Peritoneal fluid analysis revealed predominantly lymphocytes. She was started on Cat 1 ATT from DOTS in view of high suspicion of Tuberculosis.

Figure 2: Image showing Cu T embedded in bowel during laparotomy.

DISCUSSION

The prevalence of missing intrauterine contraceptive device among users is 0.5-2%.[4] Missing IUCD is when Cu T threads are not visible in vagina, as a result of expulsion, perforation of uterus, but occasionally there is translocation of Cu T in peritoneal cavity.[5] Primary perforation occurs at time of insertion, inappropriate timing of insertion, soft uterine wall, wrong measurement of uterocervical length.[6]

Migrated IUCD may not be discovered until it is found missing. Sometimes they present with pain abdomen as in our case. Post insertion women should have follow up visits as recommended. First visit should be at the first menstrual period or after 1 month whichever is earlier. Subsequently after 3 months, thereafter once a year for the exclusion of infection, abnormal bleedings, the proper position of Cu T.[7] All migrated IUCD must be removed as it can enter the peritoneal cavity and cause bowel and bladder perforation and fistula formation. In the present case report Cu T was inserted by a health provider at peripheral hospital and she did not have regular follow up and patient came to know about missing Cu T when she started having pain abdomen.

CONCLUSION

Patients should have IUCD insertion under specialist supervision using appropriate technique with regular follow up and should be intervened as soon as possible in case of missing thread.

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