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Migrated Intra-uterine Contraceptive Device: The Need for Proper Counselling

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ABSTRACT

The migration of IUCD into the bladder has been reported in several literatures^{1,2}. This sometimes occurs at the time of insertion when the uterus is perforated, but may also occur by erosion into uterus and bladder following insertion¹. The device is a common method of contraception in the developing world due to its low cost, efficacy and availability³. We present the case report of a 40 year old infertile female who had an unconsented forgotten intra-uterine copper-T contraceptive device that migrated into the bladder.

CASE REPORT

Mrs A. E is a forty year old lady, who presented to the urology clinic of our centre with one year history of lower urinary tract symptoms characterized by frequency, urgency, nocturia, strangury and painful terminal haematuria. These symptoms have been persistent since onset, she had never seen stone in her urine before, had no history of urethral instrumentation nor childhood haematuria, no history of exposure to benzene derivatives and no symptoms suggestive of metastases.

Prior to her presentation to our centre, she has been to several private hospitals where she had repeated urine investigations (urinalysis and urine microscopy, culture and sensitivity) and received several antibiotics which did not ameliorate her condition.

She is neither diabetic nor hypertensive, but is being evaluated and treated for infertility since she got married 10 years ago.

Her menses is currently irregular and flows for five days with no premenstrual pain; she has had 2

spontaneous abortions the last one being 3 years ago. She had emergency caesarean section for intra-uterine foetal death 2 years ago and since then has not been pregnant. She gave no history of usage of any contraceptive device before now and was not aware that a copper was inserted in her uterus by her gynaecologist. She takes alcohol occasionally but does not smoke cigarettes.

Physical examination findings were essentially normal but for a midline subumbilical scar and suprapubic tenderness

Urine microscopy and culture yielded a heavy growth of E.coli , ultrasonography scan showed a hyperechoic shadow within the bladder cavity with acoustic shadow suggestive of a calculi with no thickening of the bladder musculature nor any other pathology in both the bladder and upper urinary tract.

Plain abdominal radiograph of the pelvis revealed a radio-opaque shadow within the pelvic cavity suggestive of a copper T device surrounded by a calculi within the urinary bladder fig1

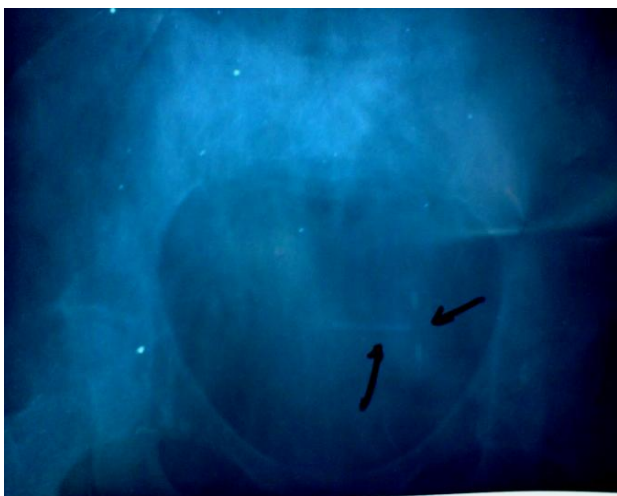


Fig1: Copper T Device Within The Bladder

She had cystolithotomy with intra-operative finding of a large vesical calculi measuring 10x8cm casted around the copper T device.fig 2

Post- operative care was uneventful and she has been discharged from our out-patient clinic.



Fig 2: Retrieved Stone

DISCUSSION

Several reports of migrated IUCD have been documented in literature^{1,2}. The mechanism of migration is not clearly documented; however this can occur at the time of insertion if the uterus is perforated and by erosion into the uterus¹ especially when the device is forgotten as in the index case. Previous caesarean section is one of the factors implicated in the perforation of the uterus by IUCD. The risk is higher if the device is inserted in the post-partum period as the consistency of the uterus is soft and the associated strong uterine contraction further increases this risk². Postponement of insertion of the device for three months after delivery has been shown to reduce the risk. The insertion in the index patient must have been done within the post-partum period.

Migration can be incomplete or complete. In the former type, the device remains attached to the myometrium whereas, in complete migration, the device may be situated in any site in abdomen³. In very rare cases, migrated IUCD can be located in lower anterior abdominal wall⁴. The rate of uterine perforation occurs in 1/350 to 1/2500 insertions⁵. In the index case the migration was complete as the device was completely intra-vesical.

The presence of lower urinary tract symptoms and absence of the thread of the device usually suggests migration⁶; however in the index case the patients had obvious symptoms including painful terminal haematuria, frequency, urgency, and nocturia. The thread of the device was not sought for initially as the information of IUCD insertion was not obtained from the patient. This unconsented insertion of IUCD must have led to the delay in accurate diagnosis for one year before referral to our centre as the patient was repeatedly treated for cystitis during this period.

Regular self-examination, investigation of persistent pain, or disappearance of strings may detect migration early⁶. Therefore, it is important that patients are properly counselled before insertion of the device so that appropriate history which will aid appropriate diagnosis can be obtained early in the rare case of migration. This index case also serves to remind us that patients presenting with features suggestive of recurrent cystitis should have radiological evaluation as foreign body like IUCD device apart from other anatomical anomalies might be responsible.

The migration in this patient probably occurred by erosion into the bladder as lower urinary tract symptoms started one year after the caesarean section during which period the device must have been inserted.

Transvaginal and transabdominal sonography are useful methods of detection of migrated IUCD, in our patient transabdominal sonography was very helpful in this regard.

The presence of vesical calculi with radio-opaque device embedded in it as was the case in our patient is usually diagnostic, though the device can migrate without calculi forming around it as is usually the case when the patients presents early.

Cystolithotomy was done for this patient as the stone burden was high, cystolitholapaxy with forceps extraction of IUCD is usually carried out for smaller sized stone.

CONCLUSION

Patients for IUCD insertion should be properly counselled. The possibility of migrated IUCD should be entertained in any woman of child bearing age with persistent LUTS, so that these cases can be identified and treated early.

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