# ECTOPIC PREGNANCY WITH I.U.C.D.

**(A Case Report)**

by

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Lippes Loop being very cheap as an intra-uterine contraceptive device (I.U.C.D.) is rapidly getting popular in spite of some complications that follow. Ruptured ectopic pregnancy with I.U.C.D. in the uterus, is a rare complication jeopardising the life of a patient, and a case report of such a patient is worth recording.

Mrs. J., a Hindu woman (married), 28 years, had her first delivery soon after marriage, 7 years ago. The second child (male) was only 1½ years old. She had requested for sterilisation but she was advised that it would be done when her only son would grow up to 3 years since infantile mortality in our country is very high.

Her menstrual history was regular with normal flow—5/28-30; regular, moderate, painless.

On 28th October 1965 she got Lippes loop inserted at a Family Planning Centre. Her menstrual periods though regular, became profuse, lasting for 7 to 8 days. She had her periods on 26th November 1965, 26th December 1965 and 26th January 1966, but this time the bleeding continued till 10th February when it was excessive. On March 29th, bleeding was again profuse followed next day by vomiting and severe pain in the abdomen. On 9th April she was admitted for respiratory distress with retention of urine and vomiting. Bowels had moved 24 hours before.

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She looked quite pale with pulse 126 per minute, abdomen tender and distended. There was typmpanitic note on percussion but the flanks were dull. Tem. 97., B.P. 100/60, heart and lungs N.A.D., except for fast pulse and respiration. Bladder was catheterised, Hb. was 40%, urine NAD. I.U.C.D. was removed easily by pulling on the tail threads. Nothing could be made out because she kept the abdomen rigid. Movement of the cervix elicited tenderness though not marked. A boggy feel was noted in the posterior fornix. A provisional diagnosis of ectopic was made though the almost continuous bleeding made one wonder as to when conception could have taken place.

Colpopuncture: Blood was aspirated confirming the diagnosis of ruptured ectopic. Injection morphia gr. ¼ was given and blood sent for grouping and cross-matching.

Under general anasthesia laparotomy was performed and blood transfusion started. She belonged to Group A (II) and was Rh positive. Three bottle of 350 cc of blood were transfused by means of syringe.

Whole abdomen was full of blood clots and quantity removed was more than one pint.

The right fallopian tube had ruptured and was removed. The left tube was found normal and it was ligated to effect sterilisation. Plication of round ligaments was done. After effecting peritoneal toilet the abdomen was closed.

The specimen shows rupture of the tube between the ampulary and isthmic portions of the right fallopian tube.

*Discussion*

With the increasing trend in loop insertion one should keep ectopic pregnancy at the back of one's mind when such patients complain of vaginal bleeding, which they often do, because if not diagnosed, it could be fatal.

Ruptured ectopic is a calamity which a gynaecologist has to deal with immediately in order to save the life of a woman. Was I.U.C.D. responsible for this calamity? Would she have had it even if no I.U.C.D. was introduced as the general incidence of ectopic is given as one in 300 pregnancies?

Tietze has presented "The Fifth Progress Report of the Co-operative Statistical Programme for the Evaluation of Intra-Uterine Contraceptive Devices". The report covers 11,222 first insertions with aggregate period of use amounting to 85,782 woman months. There were 187 pregnancies prior to an expulsion noticed by the wearer, or a removal. Of these, 99 pregnancies occurred with the device inside at the time of conception. Seven of these 99 pregnancies, or I in 14, were ectopic, a very high incidence indeed. Dr. Jack Lippes gives a figure of 4 ectopic pregnancies in 23 cases in the series of 7,000 cases that conceived with the loop in situ.

The mechanism of I.U.C.D. for preventing pregnancy is by discouraging the nidation of the ovum in the uterine cavity. It may be preventing the utilisation of hormones locally, or creating a hormonal imbalance by altering the cell permanently, and vascularity, or enzyme patterns of the uterus so that the fertilised ovum cannot get hold on to the decidua. It may thus be considered as an abortion in a very early stage.

Others believe that the foreign body in the uterus causes hurried peristalsis of the fallopian tube so that the ovum is propelled into the uterus before it has a chance to get fertilised, nay before the maturation division takes place i.e. before the polar bodies are thrown out.

The occurrence of ectopic (1 in 14) with I.U.C.D. stresses that in the majority of cases fertilisation must be taking place. This is, perhaps, the reason why the Episcopal Committee appointed by the Pope cannot come to a conclusion whether I.U.C.D. could be permitted by the Church.

In the vast majority of cases of ectopic there is a history of a long period of sterility, either caused by partial tubal infection or congenitally underdeveloped long fallopian tubes. In the present case of ectopic with I.U.C.D. there is no history of a long period of sterility—last child was born only 1½ years ago. The tubal factor, therefore, was not responsible for delayed transit of the fertilised ovum into the uterus. Is it possible then that just one m.m. or less of the interstitial end of the tube was obstructed by one of the contours of the loop? High incidence of ectopics (1 in 14) amongst the pregnant with I.U.C.D. keeps one thinking!