

AN UNUSUAL FOREIGN BODY IN THE BLADDER

by

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Perforation of the uterus by the Lippes loop is being gradually recognised as one of the serious complications that could occur, particularly when the loop is being used extensively. The migration of the loop outside the uterus is most often into the peritoneal cavity. A few cases have been reported where it has burrowed into the broad ligament (Mallik 1968). Vani *et al* (1967) reported the migration of a Grafenberg ring into the rectum. In the case reported here the loop migrated into the bladder.

Case Report

Mrs. K., 22 years, was admitted on 6-12-1967 with a history of incontinence of urine which started 4 months back, after a forceps delivery at a local hospital. Obstetrical history: She was a second para — first delivery was by a caesarean section, 4 years ago. She had an IUCD inserted two years after this delivery, but conceived after one year. She had not noticed the expulsion of the loop. Second delivery was by a difficult forceps (baby alive). Sterilisation operation was done on the 3rd day. Dribbling of urine started from the 6th day after delivery. She was having lactational amenorrhoea at the time of admission.

She was a well nourished woman. A routine examination of various systems did

not reveal anything abnormal. Vaginal examination showed a small vesicovaginal fistula, 1½" above the anterior lip of the cervix. Uterus was normal in size and fornices were free. A plain x-ray of the abdomen showed the Lippes loop in the pelvis in an apparently normal position.

On 12-12-1967, under general anaesthesia, the cervix was dilated and the uterine cavity was explored for the loop. There was no evidence of the loop inside and during the procedure, it felt as though the uterine wall had yielded in one place. Since there was no definite evidence of perforation, the patient was watched carefully. There was no immediate change, but about six hours after the exploration she began complaining of pain in the lower abdomen, the pulse rate started becoming rapid and blood pressure started falling. An immediate laparotomy was done under general anaesthesia. There was some blood in the peritoneal cavity and there was a perforation in the region of the left cornua and a small haematoma in the left broad ligament. The uterus was small in size and hyperinvolved. There was no trace of the loop inside the uterine cavity or in the peritoneal cavity. A sub-total hysterectomy was done. She was complaining of vague pain in the lower abdomen in the postoperative period. Hence, the x-ray of the abdomen was repeated. The loop was seen in the same position as in the previous x-ray. A cystoscopy was done on 13-1-1968. There was evidence of cystitis and a large foreign body was seen inside the bladder surrounded by concretions. An attempt was made to remove the loop through the cystoscope with an endoscopic forceps, but it was not successful. Hence a suprapubic incision had to be made and the loop removed. The patient made an

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uneventful recovery and the fistulous opening closed spontaneously.

Discussion

Incidence of perforation of the uterus by an intra-uterine contraceptive device is very variable. Tietze (1965) gives an incidence of 0.6 per 1000 for Lippes loop. Hall (1966) reports an incidence of 1 in 969. Chakravathy and Mondal (1968) give an incidence of 1 in 4,000.

Foreign bodies have been known to travel beyond the point of entry and be found later in an entirely different tissue. Such movements can best be explained by muscular activity of the organ pushing the foreign body along. Perforation of the uterus by the device can occur either during the insertion or spontaneously later.

In the case reported, it seems probable that the perforation into the bladder might have occurred at the time of insertion of the loop, the bladder being adherent to the lower uterine segment after the caesarean section. The patient was having a vague pain in the lower abdomen which was attributed to the presence of the loop inside the uterine cavity. She had a difficult forceps delivery about a year after the insertion of the loop, followed by a post-partum sterilisation. Since the dribbling of urine started a week after the delivery, more attention thereafter was paid to the vesico-vaginal fistula which was the more distressing complaint. A plain x-ray of the abdomen showed the loop in the pelvis in an apparently normal position. Looking back on it now, it would have been more sensible, to presume that after

the vaginal delivery, the loop, if inside the uterine cavity would have been expelled with the placenta and the loop should have been looked for in an adjacent area outside the uterine cavity. Because of the rarity of this condition it was not thought of till much later, when no trace of the loop was found in the uterine cavity or in the peritoneal cavity. The exploration of the hyperinvolved uterus, though done carefully with a blunt instrument, still resulted in an injury to the uterine wall. Another significant fact was that the fistulous tract healed up spontaneously when the loop was removed.

Comments

A case of migration of the Lippes loop into the bladder is reported. From the evidence available, it is not possible to conclude whether this occurred at the time of insertion of the loop or subsequently. The inference is that women who complain of persistent pain in the lower abdomen after a loop insertion require thorough investigation, the probability being that there could be some misplacement of the loop. It is needless to say that the greatest care is to be taken in the actual insertion of the loop. A careless insertion and misplacement of the loop results in the loss of faith of the people in the loop as a means of birth control, besides causing anxiety and physical pain to the patient.

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