UTERINE PERFORATION BY LIPPES LOOP

(A Report of 3 Cases)

by

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Intrauterine devices have been used throughout the world to provide women with the means to plan their pregnancies and thus to place some restraint on the population explosion. Lippes loop has been in use throughout India since 1965, and has been found to be safe, effective and acceptable. Of the various complications caused by this device, perforation of the uterus is likely to be dangerous.

Case Reports

Case 1

Smt. B., aged 30 years, was admitted on 7-5-1967 for irregular vaginal bleeding and cramp-like pain in the lower abdomen for 1½ months. She was a 6th para, the last child being 2 years old. A Lippes loop was inserted 2 months after her last delivery. A year later she conceived with the loop in place.

At 10 weeks of her pregnancy, an attempt at removal of the loop failed and she was advised a sterilization operation which was undertaken on 1st December 1966.

On 31-3-67 she aborted completely at about 22 weeks of gestation. At a check-up examination, the thread was visible and four unsuccessful attempts were made to remove the loop. Irregular uterine bleeding continued, each episode being preceded by cramp-like pain in the lower abdomen.

On examination she was anaemic, and the pulse and blood pressure were within normal limits. Systemic examination showed no abnormality clinically. Bimanual pelvic examination revealed an anteverted, bulky, mobile uterus of rather soft consistency. Fornices were free. The cervix was healthy and there was slight bleeding. Thread was not seen. An antero-posterior x-ray showed the distorted loop to be in the pelvic cavity. Hysterogram proved the loop to be extrauterine (Fig. 1), but close to the uterus.

Laparotomy was performed on 1-6-1967. The loop was seen under the anterior leaf of the right broad ligament, close to the uterus, and was removed. The site of perforation could not be marked. She recovered uneventfully.

Case 2

S., aged 28 years, 6th para with all living children, was admitted on 19-2-68 on the 13th postpartum day. There was a history of insertion of loop on 13-5-67, 6 months after her 5th child and during the lactational amenorrhoea. She did not menstruate after that and was found to be pregnant. She delivered normally in a hospital on 7-2-68. The loop was not expelled during delivery. On exploration, the loop was not found in the uterine cavity. On examination, she was of average build and slightly anaemic. The pulse and blood pressure were within normal limits and systemic examination revealed no abnormality.

Pelvic examination showed the uterus was soft and enlarged to 12 weeks size. The cervix was patulous and the lochia normal. Blood counts were within normal limits. A straight x-ray showed the loop in the pelvic cavity. On a hysterogram (Fig. 2) the loop

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was visualised outside the uterine cavity. A laparotomy on 26-2-68 found the loop under the peritoneum on the posterior wall of the uterus at the level of internal os and it could be removed easily after incising the peritoneum. The loop size was 27½ mm. and the thread was absent. She recovered uneventfully.

Case 3

S., aged 22 years, was admitted on 22-3-68 with continuous vaginal bleeding for 2 months following amenorrhoea of 3 months. A loop had been inserted on 21-2-67. There was no trouble for 10 months, after which she conceived. The pregnancy was confirmed at the 3rd month. Her menstrual cycles were regular without any change after loop insertion. She was a 5th gravida, para 3, last childbirth 1½ years ago. On examination she was anaemic, pulse 104 per min, BP. 108/64 mm. Hg. Chest and abdomen were clinically normal. Vaginal examination—uterus was anteverted, firm and enlarged to 8 weeks; cervix was soft. Internal os admitted one finger and retained products were felt. An evacuation operation was performed under anaesthesia, when the loop was felt easily in the pouch of Douglas through the posterior fornix. A laparotomy was proceeded with.

On opening the abdomen most of the loop was protruding into the pouch of Douglas, only a small portion being still in the uterine wall. It was pulled out and the rent (at the level of internal os) was repaired. She made a quick recovery.

Discussion

This complication with Lippes loop is being encountered more and more presently as the number of insertions is increasing. Similar cases have been reported in India by Majumdar (1966), Nanda (1966), Banerjee and Mukherjee (1967), Gadgil and Anjaneyulu (1967) and Walmiki, *et al* (1967). The incidence in our cases can not be given as all the cases came from distant areas.

Mechanism of Uterine Perforation

The loop may perforate the uterus during insertion, during attempts at removal or spontaneously. The involuting postpartum uterus, acute flexion of the uterus and the large size of loop have been considered as contributory factors. All three of our cases had conceived, one ending in a full term delivery and two in abortions. In all, there was a history of failed attempts to remove the loop. The soft uterus and attempts at removal might have been responsible for uterine perforation. In all the cases, loop size was 27.5 mm.

Care in examining the patient, judicious timing of the insertion, use of volsellum traction to straighten the uterus, sounding of the uterus and gentleness during the insertion and ejection of the device into the uterus would greatly reduce the incidence of perforation. (Burnhill, 1967).

Summary

Three cases of perforation of uterus by Lippes loop are reported. All the cases were associated with pregnancy. Various causes of perforation and possible precautions to avoid this complication have been outlined.

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Figs. on Art Paper VI and VII