PERFORATION OF UTERUS WITH COPPER 'T'

(A Case Report)

by

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During last few years, intrauterine contraceptive device has gained world-wide popularity and acceptance. It is used as an effective means of contraception.

Perforation of the uterus is one of the least common but most serious complication associated with IUCD.

Disappearance of nylon thread from the cervical os without spontaneous expulsion, needs thorough examination of the patient. Perforation is not as infrequent as reported in the literature as many asymptomatic cases must have occurred.

Herewith an unusual case is reported, where perforation of the uterus was asymptomatic and was diagnosed when patient came for check up, when she had suspicion of pregnancy.

CASE REPORT

Mrs. S.D., aged 30 years, got admitted on 9-8-1978 in Medical College, Nagpur with history of ammenorrhoea of 1½ months. There were no other complaints.

She gave history of insertion of CuT 6 months back by some private practitioner, which was removed after one month for some side-effects.

This time, she gave history of CuT insertion 3 months back before admission. This time CuT insertion was done on 9th postmenstrual day. There was no history of vaginal bleeding or pain in abdomen, after the insertion of CuT. There was no bowel and urinary tract complaints. This patient never got herself checked from the gynaecologist after its insertion or never saw CuT expelled.

Obstetric History: Patient was para 2, Last childbirth was 2 years back.

Menstrual History: Previous menstrual cycles were regular, even after insertion of CuT. Last menstrual period was 6 weeks back.

Examination: Patient was young, moderately built, pulse-90/mt. B.P. 120/80 m.m. Hg. Heart and lungs were normal. Abdominal examination was normal.

On speculum examination, cervix and vagina was congested. Threads of CuT could not be visualized.

Bimanual vaginal examination revealed uterus enlarged to 8 weeks' size, soft, fornices were clear. Patient was insisting for medical termination of pregnancy.

X-ray was taken to locate the CuT in the abdominal cavity, which showed CuT displaced to right corner of the brim of pelvis and was inverted (As shown in the photograph).

The patient was posted for suction and evacuation and laparotomy on 12-8-1978.

Under spinal anaesthesia suction evacuation was carried out in usual way and products of conception were removed completely. CuT was not felt in the uterine cavity, so exploratory laparotomy was carried out.

Abdomen was opened by midline subumbilical incision. Uterus was well contracted, firm, bulky. Left tube and overy were normal. On right side a loop of omentum was adherent to the infundibulopelvic ligament and the CuT was palpated in the substance. An incision was made on the adherent loop of omentum and CuT was removed with the help of artery forceps. Omental adhesions were separated and ligated. There was no bleeding from the raw area. A puckered old scar, was identified on the fundus at the top which could be the site for perforation of CuT.

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Her postoperative period was uneventful. Patient was discharged on the 10th postoperative day.

Discussion

CuT was first designed by Tatum in 1966. It has been found, that side effects such as bleeding, pain and expulsion rate are much less than other contraceptive device, though pregnancy rate was high. Copper has increased the efficacy. Again, Tatum (1972) found that incidance of perforation with this device was almost negligible. There have been only few case reports published until now where perforation has occurred, out of which one was noted by (Gupta *et al* 1975).

Since the newer device is made up of inert material, a polythene, or non-reactive metal, the question arises as to whether immediate surgical intervention in necessary.

Once device is found, to be lying in the abdominal cavity, the usual treatment reported is to do a laparotomy.

All patients who develop abdominal pain, immediately after insertion, perforation should be ruled out. It is true that there is high incidence of abdominal cramp following the insertion of device.

The most important factors which contribute to perforation at the time of insertion are: (1) The manner in which the device is introduced. (2) The type of device and introducer. (3) The consistency of the uterine wall.

In this patient, most probably, perforation must have occurred at the time of insertion only. The puckered area at the fundus may be the site from which CuT must have expelled in the abdominal cavity.

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References

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See Fig. on Art Paper VI