LOOP TRAVERSING THE UTERINE WALL

by

ASHA SINGHAL,* M.S., D.G.O.
A. SRIVASTAVA,* M.B.,B.S.
and
V. MALANI,* M.B.,B.S.

Loop is a popular device for family planning. Its insertion and removal are easy and require no anaesthesia. It is generally safe, though minor complications like bleedings, backache, leucorrhoea are not uncommon. It is very rare that the loop perforates the uterus and escapes in the peritoneal cavity. The incidence of perforation is reported to be 0.05-0.87 per cent. (Agarwal and Singhal, 1977). We are reporting a case where we found the loop in the process of traversing the uterine wall.

CASE REPORT

Mrs. P. P., 25 years old she came for a routine check up on 20-1-1979. The loop was inserted 1½ years back.

Obstetric History: She had 2 full term normal deliveries. The last child was 1½ years old.

The Pelvic examination revealed a retroverted normal sized uterus and clear fornices. The loop thread could be felt. On speculum the loop of thread was confirmed. There was erosion of cervix for which cautery was done.

On 7-3-1979, she came complaining of severe backache for the last few days. The general and systemic examinations were normal. Speculum examination confirmed that the loop was in situ. The cervix was healthy.

On 24-3-1979, she presented with 14 days' over due period. Vaginal examination showed that the uterus was bulky and soft, though loop thread was felt and seen at the external os. As she did not want to keep this pregnancy it was decided to do MTP.

*Cadel Road Municipal Hospital, Bombay.
Accepted for publication on 28-12-79.

On 26-3-1979, she was taken up for MTP; the cervix was dilated. The loop was not pulled out in the beginning lest she may start bleeding before dilatation. The nylon thread of the loop got pushed in during the procedure, hence a suction curette No. 10 was passed without bothering for the loop. The products of conception were sucked out. Now the thread was seen at the external os. An attempt was made to pull it out but it was felt as if the loop was firmly adherent On using more force the thread came out leaving the loop behind. The uterine cavity was curetted but still there was no trace of loop anywhere. Finally loop hook was also tried with the hope that the loop may be lying in one of the cornu. All the search was futile. The patient was given methergin and watched for bleeding. She was put on antibiotics.

On 27-3-1979, there was no bleeding, the general condition was good. An X-ray was advised but the relatives were reluctant.

On screening on 30-3-1979, the loop was seen in pelvis. A loop hook was passed to remove the loop but the latter could not be found.

With this exploration the patient started bleeding hence the procedure was abandoned. An X-ray was taken.

As the X-ray showed the loop in the pelvis in the region of the uterus and the screening had also shown the loop hook touching the loop, we decided to explore the uterine cavity again.

On 2-4-1979, under general anaesthesia the cavity was explored by finger, curette and loop hook but with no success. The procedure was abondoned. We decided for laparoscopy with preparations for laparotomy.

On laparoscopy (5-4-1979), the loop was not seen in the pouch of Douglas or in lateral aspects of uterus. Again the uterine cavity was searched but in vain. We were about to consider laparotomy. Meanwhile, as the uterus was

being moved to push away the bowels in order to have another look in the pouch of Douglas, a small curved ridge was seen on the anterior surface of the uterus. This ridge was explored with laparoscopy forceps and it turned out to be the proximal end of the loop.

The loop was caught by laparoscopic forceps and gradually pulled out. The uterus started bleeding at the loop site; hence pressure was given by a piece of gelfoam caught by the forcepts. After a few minutes the bleeding stopped. The gelfoam was left at the site and the laparoscope was removed.

Antibiotics were continued for a few days and the patient watched for 24 hours. She had an uneventful postoperative period.

Discussion

In the firm uterus possibily the IUD slowly erodes the uterine myometrium to reach the peritoneal cavity. This mechanism of escape is confirmed by our observations in the above case where the loop was still embedded in the uterine wall—the proxlmal end being under the serosa and the thread with the tail end still in the uterine cavity projecting from the os. Obviously it was not due to the injury of uterine wall by the introducer. The gradually appearing symptoms of intense backache could suggest a slow erosion of the uterine wall.

Some workers have advocated conservative and others an active approach. The advocates of conservative treatment feel that there is no point in opening up for an inert, harmless, polythene material. We have seen a case where the loop was lying adhered to parietal peritoneum. This was accidentally detected while dolng hysterotomy.

The other group favour laparotomy as they feel that there are chances of intestinal obstruction and adhesions. They also mention about the psychological upset that it may cause and the loop phobia which she will give to other women friends and relatives.

Summary

A case is described where the patient in whom a loop was inserted conceived. MTP was performed. Although the thread of the loop was seen at the external os, loop could not be found in the uterine cavity. At laparoscopy the proximal end was detected at the serosal surface of the uterus and the loop was in the uterine wall. It was removed by the use of a forceps at laparoscopy.

References

1. Agarwal, S. and Singhal, N.: J. Obstet. Gynec. India. 27: 263, 1977.