

MANAGEMENT OF DISPLACED INTRA UTERINE DEVICES

By

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SUMMARY

Displaced IUCD in peritoneal cavity requires removal in majority of cases. We have come across 6 cases in two year period 1984-85, where laparoscopic removal was possible in 2. Laparoscopic removal has proved to be a simple alternative to laparotomy.

Introduction

In spite of the efficacy, complications like haemorrhage infection and perforations continue to occur. The incidence of uterine perforation by IUCD is difficult to establish because the condition often remains undetected except as an incidental finding. Incidence of uterine perforation with CuT varies from 1:5000 Tatum (1973) to 1:192 Cederquist (1975). Alwani from India (1978) reported incidence of 1:1400 insertions. By virtue of its shape CuT has better physiological adaptability to the uterus, but as it has three pointed ends it is more prone to perforation.

Most of the perforations occur at the time of insertion when it may be associated with pain or bleeding. Also IUCD can penetrate the uterine walls slowly and migrate into the peritoneal cavity or broad ligament. Rare sites such as urinary bladder and abdominal wall have also been reported. Migration through fallopian tubes is also possible.

Displaced IUCD no longer offers contraceptive protection. The general policy in the management of IUCD is to remove

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it whenever it is an active IUCD, even if it does not produce symptoms.

The present paper deals with our experience with the laparoscopic removal of migrated IUCD's in 6 cases during the two year period 1984-85.

Types of IUCD's

| Type | No. of cases |
|------------------|--------------|
| Cu T | 5 |
| Multiload Cu 250 | 1 |
| | <hr/> |
| | 6 |

Indications for removal

—Pregnancy following IUCD insertion & IUCD being extrauterine

| | |
|------|---|
| Cu T | 3 |
|------|---|

—Pain in Abdomen

| | |
|------|---|
| Cu T | 1 |
|------|---|

| | |
|------------------|-------|
| Multiload Cu 250 | 1 |
| | <hr/> |
| | 2 |

—Symptomless active IUCD with string not seen on P/S examination

| | |
|------|---|
| Cu T | 1 |
|------|---|

Place of Insertion & Cadre of Insertor

| | |
|----------------------------|--------------------|
| 1. Qualified gynaecologist | 1 (Multiload Cu T) |
|----------------------------|--------------------|

| | |
|--|---|
| 2. Primary health Centre doctor (M.B.B.S.) | 2 |
|--|---|

| | |
|--|-------|
| 3. Primary health Centre Paramedical staff | 3 |
| | <hr/> |
| | 6 |

Technique of Removal

All cases were done using a Karl Storz single puncture operating laparoscope. After locating the site of the displaced IUCD, using a fallope ring applicator, the adherent omentum may be freed from the IUCD. The IUCD is caught by the tongs and is partly withdrawn into the applicator and removed along with scope. The scope is reinserted, the area visualised to rule out any haemorrhage. The procedure is completed after visualizing the other parts of pelvis including the adnexa.

Results

Out of 6 cases, in 2 cases, we were able to remove the IUCD with the help of laparoscope. The patients could be sent home on the same day thereby avoiding unnecessary laparotomy. Out of these 2 cases, one was Cu T-200, whose two transverse bars had perforated the posterior surface of uterus and could be seen by a laparoscope and the vertical bar was embedded in uterine musculature of the posterior wall. And in the second case the Cu T was lying in the uterovesical pouch of peritoneum and was covered by omentum.

In the remaining 4 cases, laparotomy was required as we were not able to remove layer by laparoscope. Out of these, in one the Cu T-200 was entangled in the mesentery of the gut. In the second

it was seen at the right cornu of the uterus, posteriorly, thickly embedded in omentum. No attempt was made to remove it by Laparoscope, apprehending bleeding, which may ensue. In the third, Cu T-200 was seen on the right, side, posteriorly between the two layers of the broad ligament, where there was a ragged tear and a haematoma. The haematoma between the two layers of the broad ligament was evacuated and the ragged tear sutured. The fourth was a case of multiload Cu T-250. Patient came to us with history of IUCD insertion 10 days back in trust hospital and pain in abdomen following insertion. On examination and investigation Cu T was found to be extrauterine. Laparoscopy was done and the multiload Cu T was seen impregnated between left side of broad ligament, posterior surface and omentum and intestine. Only thread was seen and attempt was made to remove with scope, but due to lot of adhesions, it could not be removed. Laparotomy was done and Cu T-250 removed. Perforation sites on intestine and broad ligament were sutured. Postoperative period was uneventful in all cases.

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