

INTRAPERITONEAL TRANSLOCATION OF Cu-T

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SUMMARY

Clinical experience with twenty-five cases of intraperitoneally translocated Cu-T is presented. In 19 (70%) patients successful removal was achieved by laparoscopy. Effectivity, cost-effectiveness, low morbidity and patient's acceptability of this procedure V/s laparotomy and brief review of literature is discussed.

Intraperitoneal displacement of Cu-T requires removal as early as possible because it is associated with complications such as abdominal adhesions, intestinal penetration, intestinal obstruction and local inflammatory reaction with abscess formation and erosion of adjacent viscera may result if Cu-T is left in the peritoneal cavity (Heartwell and Schlesselman 1983). In our series, such Cu-T were successfully taken out by Laparoscope in 19 cases whereas in 6 patients these could not be removed on account of adhesions and exploratory laparotomy had to be performed.

MATERIAL AND METHODS

25 patients presenting with intraperitoneal translocation of Cu-T in post-partum unit of

Obstetrics and Gynaecology Department, Medical College & Hospital, Amritsar, over a period of 3½ years (June, 1988 to Dec., 1991) constituted the material for this study. 24(96%) cases were referred from peripheral dispensaries, health centres and private hospitals.

Detailed history was obtained in every case and thorough clinical examination was carried out in all the patients. Diagnosis was confirmed by uterine sounding, radiological relative displacement study or ultrasonographic localisation.

TECHNIQUES OF REMOVAL

(1) By laparoscopy : Single puncture, operating, Karl Storz Laparoscope was used in our cases. The procedure was carried out under general anaesthesia in all the cases.

After insertion of laparoscope, peritoneal cavity was examined and displaced Cu-T was

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located. It was caught with the blades of punch biopsy forceps and was removed under vision. The area was observed for any haemorrhage or leak for 3-5 minutes. In 4 cases, laparoscopic tubal occlusion was done at the same time with Fallop rings. Laparoscope was withdrawn under vision and skin wound stitched with 2 cotton stitches.

(2) **Laparotomy**: Failure of Cu-T removal by laparoscope necessitated exploratory laparotomy in 6 cases. It was performed through midline sub-umbilical incision under spinal anaesthesia. The site of translocated Cu-T lodgement was identified and isolated by abdominal packs. Cu-T was taken out by blunt as well as sharp dissection. Haemostasis was secured and abdominal wound was closed in 3 layers. Patients were discharged after removal of stitches.

OBSERVATIONS

The patients were in the age group of 18-35 years and parity varied from 1-4 living children.

Significantly in 96% cases Cu-T insertions had been carried out in peripheral hospitals by L. H. V/s A. N. Ms or Trained Dais. Only one case out of 5000 insertions was done by a junior doctor under-training in the centres had this complications. Spectrum of presentation varied from missing threads (n = 11 ; 44%) bleeding per vaginum (n = 2 ; 8%). Time interval between Cu-T insertion and seeking

treatment for its displacement varies from 3 days to 6 months.

Various intraperitoneal sites of location of displaced Cu-T are shown in Table I, highest number being in the pouch of Douglas (72%).

As shown in Table II successful removal could be carried out by laparoscope in 19(76%) cases whereas in 6(24%) exploratory laparotomy was required. No major complication was observed in any of the procedures.

DISCUSSION

Removal of translocated Cu-T could be successfully carried out by laparoscopy in

Table I

Showing the site of translocated Cu-T in Abdomen

Site of Cu-T	No. of cases	Percentage
Pouch of Douglas	18	72
Fallopian tubes	2	8
Embedded in uterine wall	2	8
Omentum	1	4
Mesentery	1	4
Colon	1	4
Total	25	100

Table II

Showing comparative results of laparoscopy and laparotomy

Name of procedure	No. of cases	Mean op. time	Average hospital stay	Mean cost of operation	Incidence complication
Laparoscopy	19	? 10 minutes	6 hours	Nil	Nil
Exp. Laparotomy	6	? 1 hour	8 days	?	?

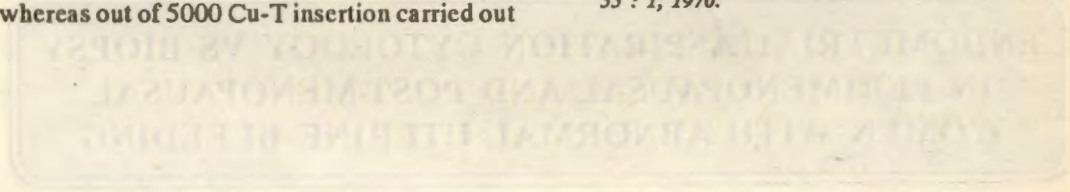
majority of patients. The procedure was found to be associated with minimal operation time, short hospital stay, early return to active life, excellent patient acceptability and low cost. On the basis of these features laparoscopic removal of translocated Cu-T can safely be advocated as the treatment of choice and laparotomy should be resorted to only in the event of its failure.

Significantly in 96% cases Cu-T insertion had been carried out in the peripheral hospital, whereas out of 5000 Cu-T insertion carried out

in our centre only one patient reported with displaced Cu-T. This underlines the urgency of proper training to the para-medical and medical staff so as to minimise the incidence of complications.

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SUMMARY

In a series of 100 cases of abdominal masses during the last 10 years, the authors have found a high incidence of displaced Cu-T. The clinical picture was typical of a displaced Cu-T. The diagnosis was confirmed by laparotomy and biopsy. The management was laparoscopic removal of the displaced Cu-T and the insertion of a new Cu-T. The results were excellent.

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