

Endoscopic Retrieval of Migrated IUCD from the Rectum

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Abstract

A 23 years old patient had presented with history of 2 to 3 cm white thread protruding out of anal orifice and pricking pain while defecating. On examination found to have impacted Cu-T in postfornix. X-ray and CT-scan delineated exact position of Cu-T. Laparoscopic retrieval was done successfully. Complications of fecal contamination was avoided by meticulous bowel preparation.

Keywords: Migrated IUCD, rectal perforation, endoscopic retrieval.

CASE REPORT

23 years old Mrs M was admitted with a complaint of thread protruding through the anal orifice (Fig. 1) and pricking pain following defecation of six months duration. There was no history of bleeding or discharge per rectum. Her menstrual history was unremarkable. She was Para 2, has delivered two children aged 3 and 1 year by the vaginal route. Her last childbirth was one year ago. She has undergone one MTP in between the pregnancies.

In her contraceptive history, in between the two pregnancies she has used IUCD three times as an interval procedure. On two occasions she got it removed at short intervals due to heavy periods. Three months following the last IUCD insertion, she missed her period and was found to be pregnant. She was told by her doctor that she had expelled the IUCD and was advised to continue with the pregnancy. At term, she delivered a healthy child and puerperal sterilization was carried out. She was a known epileptic on medication and the last episode of convulsion was one week prior to admission.

Her general and pelvic examinations were unremarkable and a 2 cm long white thread was seen protruding through the anal orifice (Fig. 1). On rectal examination the vertical limb of the IUCD was felt in the anal canal at 8 o'clock position about 5 cm from the anal orifice. By rectovaginal examination the IUCD was felt high up through the posterior fornix.

INVESTIGATIONS

X-ray of the pelvis with sound in situ showed the IUCD to be away from the uterus. In order to ascertain the exact location,

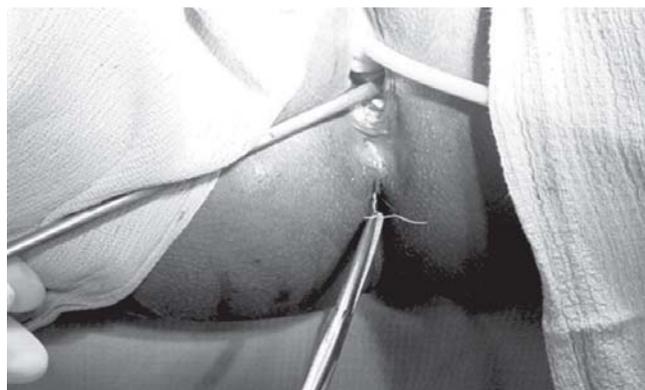


Fig. 1: IUCD thread protruding through the anal orifice

CT scan of the pelvis was taken which showed the transverse limb of the IUCD in the cul-de-sac and vertical limb in the lower rectum about 5 cm from the anal orifice. The uterus and adnexae were normal.

MANAGEMENT

As nearly 2 cm of the vertical limb of the IUCD was in the rectum and in order to avoid contamination of the peritoneal cavity with fecal matter, it was decided to remove the IUCD through the anal route. Adequate bowel preparation was carried out and informed consent was obtained. On colonoscopy, the vertical limb of the IUCD was seen 6 cm from the anal orifice and the transverse limb was not visible. As the IUCD was deeply buried attempts to retrieve the IUCD only dented the rectal wall. As forcible attempts may tear the rectum and anal canal, the procedure was abandoned and laparoscopy was decided upon.

With good bowel preparation and adequate antibiotic cover laparoscopy was carried out. The IUCD was located near the right uterosacral ligament with one arm of the transverse limb found embedded in the peritoneum with flimsy adhesions and a small inflammatory cyst suggesting inflammatory response. There was no omental or bowel adhesion. The uterus, tubes and ovaries were healthy.

The tip of the IUCD was held with forceps and the peritoneal covering was freed with cautery. There was difficulty in releasing the IUCD at the junction of the vertical and the transverse limb because of the bulk. With gentle dissection, the surrounding peritoneum was freed, releasing the transverse arm, followed by the vertical limb. There was no leak of fecal matter or bleeding. The dissected peritoneal layer at the site of IUCD perforation was closed with endoligature.

She was kept nil oral for three days and adequate antibiotic cover was given. Her postoperative period was uneventful and she was discharged home well.

DISCUSSION

Though temporary method of contraception with IUCD is a simple, safe and common procedure, complications such as perforation and displacement of IUCD do occur. In cases where IUCD thread is not visible at follow-up, it is mandatory that a thorough search should be made before declaring that, the IUCD has been expelled. Displacement of IUCD to sites such as urinary

bladder, fallopian tube, sigmoid colon broad ligament, cervix and omentum has been reported by various authors and there have been reports on perforation of IUCD into the rectum.¹⁻³ Sofat and Gupta have reported a case similar to ours where the thread was protruding through the anal orifice and was successfully removed through the anal route.⁴ In our case removal through the anal route was not possible as the IUCD was deeply buried. Whenever there is bowel involvement, with attempts to remove through abdominal route either by laparoscopy or by laparotomy, there is substantial risk of fecal contamination of the peritoneal cavity. This can be avoided by way of good bowel preparation, adequate antibiotic cover and by careful postoperative management. Involvement of surgeon is also important as bowel repair may be required occasionally.

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