

## Case Report

# Laparoscopic retrieval of misplaced copper T

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### ABSTRACT

Intrauterine contraceptive device is important part of family planning services in India. These can be inserted post menstrually, post abortal, post-delivery or in post puerperal period. Associated complications include bleeding, pain, infection, expulsion and most serious complication as perforation of uterine wall and migration to adjacent organs. We present a case of successful laparoscopic retrieval of a misplaced cuT. A 30-year-old female para 2 live 1 presented in SDMH outpatient department with right sided lower abdominal pain since one year. NCCT scan of pelvis showed IUCD in pelvic cavity anteriorly just above urinary bladder. Laparoscopic removal of cuT was done along with tubal recanalization.

**Keywords:** Contraception, cuT complication, Laparoscopic retrieval, Misplaced cuT, Uterine perforation

### INTRODUCTION

Intrauterine contraceptive device (IUCD) is one of the most effective and popular method of contraception, mainly in developing countries like India. IUCD migration secondary to uterine perforation is uncommon but serious complication.<sup>1</sup> Most widely used IUCD are copper releasing devices. Since cu-T 380A is in government supply in India and provided free of cost, hence it is the most common IUCD to be used in India. The IUCD are considered as safe, cheap with failure rate of <1 per 1000 women per year.<sup>2</sup> The reported incidence of perforation varies from 1 to 3 per 1000.<sup>3</sup> Inadequate pelvic examination before insertion and inexperience of the person predisposes to misplaced IUCD or uterine perforation.

### CASE REPORT

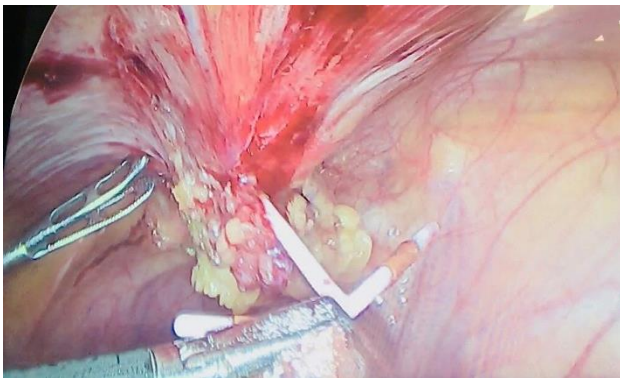
A 30 year old P2L1 female presented to SDMH gynaecology OPD with lower abdominal pain more on right side, dull aching type, intermittent, aggravated on exertion and relieved on rest. Her menstrual cycles were

regular and normal. She had two full term vaginal deliveries and history of tubal sterilization. Among them her elder son died due to bone cancer, and so she wanted recanalization also. She gave history of cuT insertion 6 years back as method of contraception. Unfortunately, she conceived with cuT in situ within one year of cuT insertion. Decision was taken at that time by her attending gynaecologist to perform MTP. Dilation and evacuation was done at 7 weeks of amenorrhea. During the procedure cuT was not found in uterine cavity. It was assumed that cuT has been expelled out without knowledge of the patient. Following that couple went for tubal sterilization as permanent method. Following the death of their elder son the couple now wanted tubal recanalization.

HSG was done as she wanted tubal recanalization also. HSG did not show any cuT in the uterine cavity. USG was done which showed cuT in pelvic cavity over bladder. It was further confirmed by NCCT of pelvis which showed normal uterus with bilateral adnexa and no ICUD in situ. IUCD was seen in pelvic cavity just above urinary bladder, abutting inner surface of recti muscle,

with lower lip embedded in superior dome of urinary bladder. Clinically per abdomen and per vaginal examination was not significant except tenderness in hypogastric region.

Patient was planned for laparoscopic evaluation. On laparoscopy, uterus with bilateral tubes and ovaries appeared normal. A thick band of omentum was attached to anterior abdominal wall. While dissecting the same, arms of cuT were visualized deeply embedded in that (Figure 1). By adhesinolysis cuT with thread was removed intact laparoscopically. This was followed by successful open tubal recanalization with tube patency test positive at the end. Post-operative period was uneventful and patient was discharged on day 3. Patient was comfortable on follow up.



**Figure 1: Laparoscopic view misplaced cut embedded in omentum.**

## DISCUSSION

Intrauterine contraceptive device is important part of family planning services in India. These can be inserted post menstrually, post abortion, post-delivery or in post puerperal period. Associated complications include bleeding, pain, infection, expulsion and most serious complication as perforation.<sup>4</sup> Missing intrauterine device occurs in 5-25% of all IUCD insertion resulting from expulsion, perforation or pregnancy.<sup>5</sup> Perforation mostly occurs during insertion and possibly the same happened in above patient. In some cases IUCD has been reported to have migrated to myometrium, appendix, colon, ovary, ileum, anus etc.<sup>6,7</sup> In this reported case IUCD was deeply embedded in thick band of omentum that was attached to anterior abdominal wall.

The common presenting symptoms are inability to feel the thread and unexplained abdominal or pelvic cramps. Diagnosis in this patient was made with USG and NCCT of pelvis. It has been suggested that IUCD located in abdominal cavity should be removed even in asymptomatic patients because of risk of adhesion

formation and damage to surrounding structures. The accepted method of treatment of a perforated IUCD is surgical removal of device by laparoscopy, hysteroscopy or laparotomy.<sup>8</sup>

## CONCLUSION

Laparoscopy is invaluable in management of misplaced IUD when simple manoeuvres fail to locate and retrieve it. Exploratory laparotomy needed only when the device could not be removed laparoscopically due to its location, Adhesions or contraindication of laparoscopy. Laparoscopic retrieval of perforated IUCD is safe and promoted with the increasing availability of laparoscopic centre in the country.

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