

A Case Report of Successful Laparoscopic Retrieval of Missed Copper-T

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Abstract: 29 year old female presented with history of missed copper-T. On evaluation with ultrasound, it was found in intrabdominal cavity. Successful laparoscopic retrieval of copper-T was done under general anesthesia.

Keywords: Copper-T, Ultrasound, Laparoscopy

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I. Introduction

Copper T (IUD) is an effective and reversible contraceptive method. Age group between 15 - 40 years women are using the IUD. One of the complication is uterine perforation at the time of insertion or later, which is seen 1/1000 to 1/2500 insertions[1]. It usually perforates at fundus, body of the uterus, or wall of the cervix. IUD pass through the uterine wall to gain access to the abdominal cavity. It causes inflammatory reaction and adhesions after gaining entry, so it should be removed as soon as possible. The medical advisory parenthood foundation considers this necessary only if the women has abdominal symptoms[2]. Laparoscopic retrieval is safe in extrauterine IUDs[3,4]

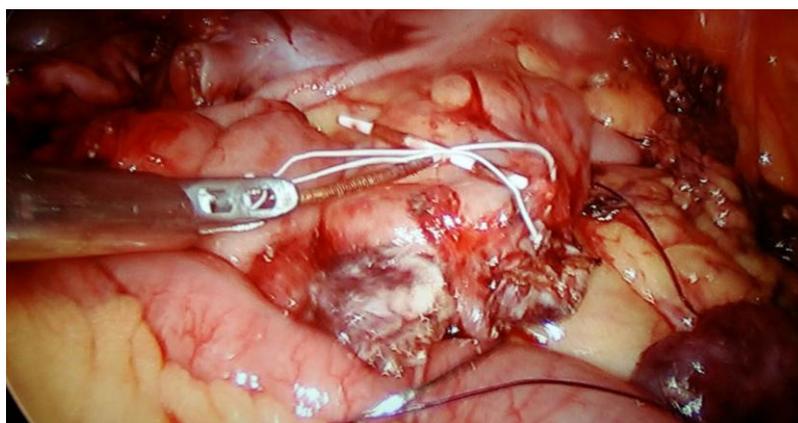
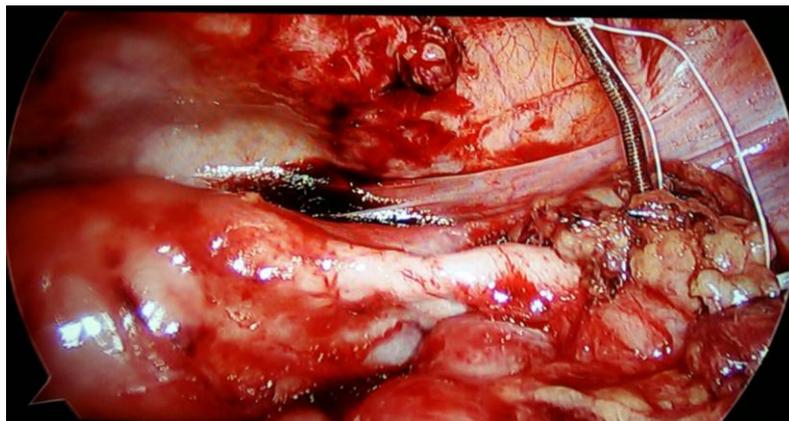
II. Method

Surgery done under general anesthesia. 10mm canula is placed through a sub-umbilical incision. Two additional ports of 5mm were place in left and right lower abdominal quadrant

III. Case Report

29 year old female underwent copper-T insertion 1 year back as contraception method. Patient became pregnant 3 months after the insertion and delivered. She presented to us for evaluation of missing copper-T, 1 month post partum. On ultrasound abdomen copper-T was found outside the uterus. CECT was done and was suggestive of intrabdominal migration of copper-T possibly due to complete uterine perforation. There was no pneumoperitoneum/free fluid in the abdomen. She was planned for laparoscopic retrieval of copper-T. Intraoperatively – one end of copper-T was in distal part of right fallopian tube, one end perforated in to distal ileal loop, other end was within abscess cavity formed around it. Fallopian tube ligated and transected, pus cavity drained, intestinal end of copper-T removed and copper-T extracted. Rent in the ileal loop closed with vicryl. Patient improved and was discharged after few days of observation.





IV. Discussion

The mechanism of IUCD perforation and translocation from uterine cavity to abdominal cavity is controversial. It is hypothesized that in addition to primary perforation at the time of IUCD insertion, it can also be aided by spontaneous uterine contraction and pressure difference between relatively higher intrauterine pressure and the low intraperitoneal pressure. Contraction of abdominal viscera i.e. urinary bladder, small and large intestines may also help in the migration and movement of the device in the peritoneal cavity. Movement of peritoneal cavity may also aid in the migration. All patient with missed IUD history pelvic ultrasound should be done. If left in the abdominal cavity it can cause bowel erosion and perforation, intrabdominal abscess. So it should be retrieved.

V. Conclusion

All migrated IUCD must be removed as the risk of bowel and bladder perforation, fistula formation is high preferably by laparoscopy. Missing IUCD should be identified using USG, pelvic X-ray/computed tomography scan. In our case ultrasound could detect missing Copper T. Removal by laparoscopy is the best approach. Early detection and regular follow-up will prevent the complications due to migrated IUCD.

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