

Laparoscopic Removal of An Ectopic Intrauterine Device From The Anterior Abdominal Wall

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The intrauterine devices (IUDs) have been used widely by women of childbearing years. In this report, we presented a case of a 25-year-old gravida 4, parity 3 woman with an abdominal wall penetration by an IUD. She had an IUD (TCu-380A) inserted immediately after dilatation & curettage. The IUD was removed laparoscopically.

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Key Words: Intrauterine device, Abdominal wall, Laparoscopy

The intrauterine devices (IUD) have been used widely by women of childbearing years, because they are safe, highly effective and inexpensive. Perforation of the uterus with subsequent migration of an IUD is a potential complication with the use of IUD. The incidence of this condition is reported to be between 0.5 and 1 per 1000 insertions.¹

Several sites of misplaced IUDs following perforation of the uterus have been described including bladder,² sigmoid colon,³ appendix⁴ and omentum.⁴ Abdominal wall penetration by the IUD was also described, but as far as we know there are only three previous cases in the literature⁵⁻⁷ We report the fourth known case of migration of an IUD into the abdominal wall.

Case

A 25-year-old woman, gravida 4, parity 3, dilatation & curettage 1 was referred to our gynecology unit with the diagnosis of a misplaced intra-abdominal IUD. Her past medical history was unremarkable. She had an IUD (TCu-380A) inserted immediately after induced abortion. The insertion was recorded as easy. At three months after insertion, she was admitted to the outpatient clinic for routine control and diagnosed with a lost IUD. She was asymptomatic. The strings of IUD were not observed in vaginal examination. On ultrasonography, the IUD was absent in the uterine cavity. The plain abdominal radiography revealed the IUD far from the uterus. The physical exam was unremarkable. A laparoscopy for IUD removal was planned.

On laparoscopy, the uterus and the adnexae appeared

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normal. The perforation site was unidentified. At operation the IUD was embedded in the omental adhesion attached to the anterior abdominal wall (Figure 1). After lysis of omental adhesions, the IUD was removed laparoscopically. Postoperative recovery was uncomplicated.

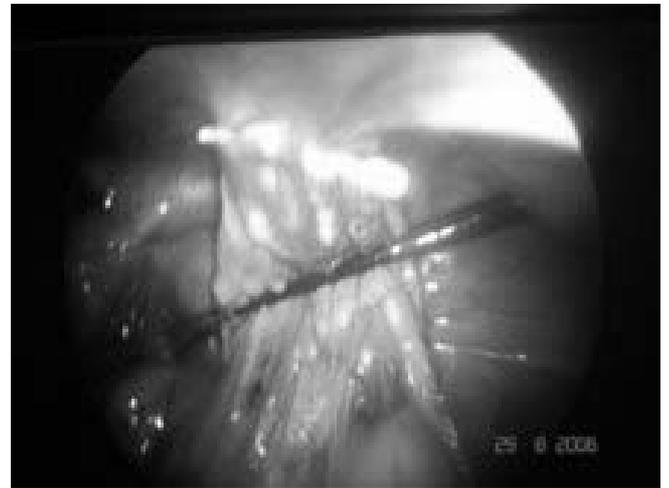


Figure 1. At the time of laparoscopy, the intrauterine device was seen attached to the anterior abdominal wall.

Discussion

We presented a case of a 25-year-old woman with an abdominal wall penetration by an IUD. Most IUD perforations occur at the time of insertion, but may also occur somewhat later. It is a well-established fact that uterine perforation is not always symptomatic like in our case. Aust et al.⁵ also described an asymptomatic perforation with the GyneFix intrauterine contraceptive implant and revealed the IUD with its knot embedded in the abdominal wall. The patient had previously been using depot progestogen continuously for four years. They suggested prolonged amenorrhea secondary to continuous progestogen use as a possible common predisposing factor. Mulayim et al⁶ reported on a lost IUD which was found in the lower anterior wall. They thought that uterine perforation had happened during a dilatation and curettage attempted for removal of the device. Dunn et al⁷ found the IUD buried in omental adhesions attached to the anterior abdominal wall in

a pregnant women. In our case the perforation might be due to the dilatation and curettage because she had an IUD inserted immediately after induced abortion. Perforation seems more likely in the immediate post-curettage state.

When the strings of the IUD are not visible in pelvic examination and pelvic ultrasonography does not demonstrate an IUD inside the uterus, abdominal X-ray should be the diagnostic tool for confirmation of the diagnosis of displaced IUD.

For lost IUD treatment, there was a disparity of opinion. The World Health Organization (WHO) has advised removal of intra-peritoneal IUD regardless of its type and location, either by laparoscopy or laparotomy, mainly because of the risk of intra-abdominal adhesion formation and possible damage to adherent organs. Several authors have stated that surgical removal should be performed only in symptomatic patients.⁴⁸ Although there is still controversy in this area, those physicians who advocate conservative treatment in asymptomatic patients should communicate the risks to the patient.

The advantage of this generally highly effective and safe contraceptive method is guaranteed only in hands of a trained operator.

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