Extruded Filshie clip presenting as an ischiorectal abscess

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ABSTRACT

This report adds to the small, but significant, literature base describing late complications following laparoscopic sterilisation. In women with recalcitrant peri-anal sepsis (who have previously undergone a sterilisation procedure) the possibility of tubal clip migration should be borne in mind. This is also an important learning point from a medicolegal point of view as patients presenting with the sequelae of clip migration will need to be counselled, and possibly investigated, with respect to the efficacy of their sterilisation procedure.

KEYWORDS

Filshie clips – ischiorectal abscess – Fistula – Sterilisation

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A 43-year-old woman presented to the general surgical clinic in November 2005 with a 4-month history of recurrent peri-anal abscess. With each episode of sepsis, the peri-anal abscess had discharged spontaneously and, on examination, the patient was found to have a fistulous opening in the 9 o'clock position. The patient also claimed that during menstruation, bleeding was noted from the fistula opening. The woman had no significant past medical history other than laparoscopic tubal ligation using Filshie clips in 2002.

An examination under anaesthesia was performed to investigate the patient's peri-anal symptoms at which time the external fistulous opening was found to communicate up into the ischiorectal fossa. At the apex of the ischiorectal fossa, a metal foreign body was found. This was extracted and found to be a Filshie clip. The cavity was debrided and a corrugated drain left *in situ*. Despite packing of the cavity and a further laying open procedure, the wound failed to heal. Subsequently, an MRI scan has demonstrated the presence of two fistulous tracts, one at 5 o'clock and the other at 7 o'clock. On the scan, both tracts appeared to communicate with each other anterior to the rectum and behind the vagina. No communication was demonstrated with either rectum or vagina. The patient has been referred to a specialist centre for further management of the fistula and the possibility of endometriosis within the fistula tract is being investigated.

With respect to the patient's gynaecological history, review of the gynaecologist's operative notes and peri-operative photographs demonstrate the satisfactory position of

bilateral double Filshie clips. Following sterilisation, the patient had made an uneventful postoperative recovery with no subsequent pregnancy or intra-abdominal pathology. Following the discovery of the displaced Filshie clip, a plain abdominal X-ray demonstrated a solitary Filshie clip on the left side of the pelvis. A subsequent Hycosy scan has shown a patent right fallopian tube, but an occluded left tube. The patient has been commenced on Prostag (leuporelin acetate) injections for her suspected endometriosis and has been offered a Mirena coil for contraception.

Figure 1 MRI scan of pelvis demonstrating horseshoe fistula anterior to rectum.

Discussion

Filshie clips are 12.7 mm long, 4 mm wide and are composed of titanium, lined with silicone rubber. They were first employed by Filshie *et al.*¹ in 1981 and are currently used in over 82% of the 90,000 laparoscopic sterilisations performed in the UK per annum.² Filshie clips are deployed by placing the jaws of the device across the fallopian tube, before being firmly locked. Avascular necrosis occurs at the site of apposition, with the eventual formation of two sealed tubal stumps. Over a variable length of time, peritonealisation of the Filshie clip occurs but, occasionally, the clip can dislodge and migrate prior to the process of peritonealisation. A comprehensive literature review was performed which has demonstrated that clip migration is estimated to occur in 0.6 per 1000 cases.³ Dislodged clips are most commonly found within the peritoneal cavity, typically within the pouch of Douglas or paracolic gutters. Rarely, tubal clips may migrate into the urinary bladder, vagina or through the anterior abdominal wall.⁴ The migration of Filshie clips to the perineum with peri-anal abscess formation has been reported in one prior case.⁵ In that case, the patient also presented with recurrent peri-anal abscesses and eventually with a peri-anal fistula. Conversely, that patient made an uncomplicated recovery with resolution of her symptoms following removal of the offending Filshie clip. An interesting point in this case was the cyclical bleeding that occurred from the fistula opening, which raises the possibility of endometriosis in the fistula tract. This may be due to implantation of endometrial tissue through the process of clip migration. No such report of this phenomenon has been found on literature review. Another interesting point here is the patency of the right fallopian

tube as demonstrated in the Hycosy scan. This is surprising given the mechanism by which clip displacement and migration is thought to occur. The fallopian tube is usually bisected following avascular necrosis at the site of ligation. In this case, peri-operative photographs confirmed that the clip had been placed in a satisfactory position and was found in a locked position when it was retrieved from the abscess cavity.

This report adds to the small, but significant, literature base describing late complications following laparoscopic sterilisation. In women with recalcitrant peri-anal sepsis (who have previously undergone a sterilisation procedure) the possibility of tubal clip migration should be borne in mind. This is also an important learning point from a medicolegal point of view as patients presenting with the sequelae of clip migration will need to be counselled, and possibly investigated, with respect to the efficacy of their sterilisation procedure.

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