CASE REPORT

Translocation of Postplacental Intrauterine Device: A Rare Complication

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About the Author

Sujnanendra Mishra worked in different remote places in Odisha as consultant in OBGYN. Presently working as ADMO (FW), BALANGIR, Odisha, India.

Introduction

Unmet need for spacing as well as limiting methods of contraception is quite high in developing countries. The reasons for non-use of contraception are many, including lack of awareness, non-availability of accessible family planning services, and limitations on women's mobility due mostly to cultural or geographical factors. During postpartum period no woman would like to be pregnant again. Delivery in an institution offers a unique opportunity to avail their need for contraception. PPIUCD allows women to obtain safe, long-acting, highly effective contraception with little discomfort and fewer side effects than while within the facility. The

popularity of the intrauterine device (IUD) and its use in the immediate postpartum period in countries like China, Egypt, and Mexico and now in India reflects safety and efficacy of this approach. Complications of immediate and intra-cesarean insertion of IUCD such as infection, bleeding, and pain are minimal, expulsion rate is little high, but overall continuation rate is encouraging. Use of interval intrauterine contraception can rarely result in uterine perforation. Perforation most often occurs during insertion, but might not be detected until sometime later. Perforation with PPIUCD was not reported till recent times. We report a case of removal of postplacental intrauterine contraceptive device (IUCD) translocated into the peritoneal cavity.

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Case Report

A 28-year-old woman, Para 2, last childbirth 12 weeks back, presented with occasional periumbilical pain for last 2 months. Her obstetrical history revealed the insertion of

postplacental intrauterine contraceptive device (IUCD) 12 weeks ago. Routine follow-up visit at 6 weeks reveals nothing abnormal except occasional pain abdomen. She attended the clinic at 12 weeks for removal because of fear of ill health due to the device inside. In course of examination, she was found to have lost string. The abdominal ultrasound showed absence of IUCD in the pelvic region with empty uterine cavity (Fig. 1). Abdominal X-ray showed a radio-opaque foreign body in the umbilical region (Fig. 2). The biochemical and hematological tests were within normal range. The patient was kept for elective laparoscopic surgery. Double-port laparoscopic equipment was used to remove the translocated IUCD. The IUCD was extra-uterine, buried in omental tissue attached to the anterior abdominal wall just above umbilicus. No evidence of any uterine injury could be found (Fig. 3a, b); the perforation might have healed. The IUCD was dissected free and removed without difficulty (Fig. 4a, b), and bilateral tubal resection using bipolar cautery was done as well on client's request. The patient was discharged after 24 h in excellent condition.

Discussion

Dislodgement of the IUCD is accompanied with different complications. One of the most frequent is unwanted pregnancy [1, 2]. It is a fact that, the dislodgment can bring the IUCD into the surrounding organs or the momentum. There are reports of dislodgment in case of interval IUCD insertion, into small intestines, recto-sigmoid colon, peritoneum, gallbladder, appendix, annexes, iliac vein, and the omentum [3, 4]. But abdominal dislodgement of postplacental IUCD is rare only few cases have been reported where the IUCD is found in and around uterine wall [5, 6]. This case is unique in its location. The most frequent anchorage of dislodged devices is omentum. We present this case of dislodgement of PPIUD up to the upper abdomen, or more specifically in the anterior parietal peritoneum above the umbilicus embedded within omentum which can occur rarely. When recognized, an IUCD that has perforated the uterus should be removed promptly because a displaced IUCD will not prevent an unintended pregnancy anymore and can cause bowel perforation, obstruction, or adhesions [7, 8].

Hans Christian Jacobaeus, of Sweden, reported the first laparoscopic operation in humans in 1910 [9]. The start of computer chip television camera was a critical event in the field of laparoscopy. This technological innovation provided the means to project a magnified view of the operative field onto a monitor and, at the same time, freed both the operating surgeon's hands, thereby facilitating performance of complex laparoscopic procedures. We find many cases of removal of displaced IUCDs using the laparoscopy since 1977 [10, 11].

Fig. 1 USG shows empty uterus (missing IUCD)

Fig. 2 Abdominal X-ray AP showing the radiopaque IUCD

Treatment of a displaced IUCD is its early surgical removal to avoid potential risk of damage to intestine and bladder, also adhesions and obstruction following infection and inflammation. Laparoscopic removal of the displaced IUCD has become popular. Laparotomy is reserved only in cases where laparoscopy may not be successful [4, 12]. We removed the displaced IUCD by laparoscopic surgery, and at the same time performed the sterilization operation on request. Postoperative period was uneventful. The patient was discharged from the hospital on the next day. To our knowledge, this is the only reported case of displacement of postpartum IUCD into upper abdomen possibly due to perforation during insertion.

In conclusion, now it is clear that perforation and abdominal translocation can occur with PPIUCD.

Fig. 3 Intact uterus during laparoscopy

Fig. 4 IUD “in situ” and removed IUD “as seen” under laparoscopy

Therefore, it is imperative that only competency of health personals providing PPIUCD be the soul criteria for certification and every provider must be aware of such a complication. We have found laparoscopy as the method of

choice for the removal of the dislodged IUCD because of the patients' comfort and minimal hospital stay. Government should also think of extending compensation packages for IUCD users and indemnity for providers in order to popularize PPIUCD and to encourage the providers.

Author Contributions Dr. Aswini Pujhari and Dr Benudhar Pande designed the work and wrote the paper and performed surgery at Samaleswari Multispeciality Hospital Bolangir, Odisha, India.

Compliance with Ethical Standards

Conflict of interest The authors declare that there are no competing interests.

Ethical Statement Author certifies that he has no commercial associations (e.g., consultancies, stock ownership, equity interest, patent/licensing arrangements) that might pose a conflict of interest in connection with the submitted work.

Informed Consent Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the journal's Editor-in-Chief.

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