

CASE REPORT

Embedded Intrauterine Contraceptive Device with Cervical Fibroid

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ABSTRACT

Intrauterine contraceptive devices (IUCDs) are among the most frequently used methods of contraception since 1965. An embedded IUCD is a situation where there is an abnormally positioned IUCD within the endometrium or myometrium, however, without an extension through the serosa. We are reporting an interesting case that presented with a missing thread, pain in lower abdomen, and menorrhagia with incidental diagnosis of cervical fibroid.

Keywords: Displaced IUCD, Embedded IUCD, Missing IUCD thread.

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INTRODUCTION

Intrauterine contraceptive devices (IUCDs) are among the most frequently used methods of contraception since 1965.^{1,2} In developing countries like India, IUCDs are popular reversible method of contraception due to easy availability, low cost, and considerably less side effects.³ The main drawback of this method in a country like India is lack of proper follow-up. The patients with misplaced IUCDs and embedded IUCDs may present with pain, bleeding, pregnancies or "lost strings," or they may remain asymptomatic.

An embedded IUCD is a situation where there is an abnormally positioned IUCD within the endometrium or myometrium, however, without an extension through the serosa. An IUCD can become embedded in the wall of the uterus or within the cervix.⁴

We are reporting an interesting case that presented with a missing thread, pain in lower abdomen, and menorrhagia with incidental diagnosis of cervical fibroid. She was operated at Jeswani Multispeciality Hospital, Nagpur, India.

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CASE REPORT

A 42-year-old lady, P2L2A1, presented with complaints of menorrhagia since 1 year, pain in lower abdomen since 10 months, and missing IUCD thread since 10 months. Her IUCD was inserted 12 years back. She had no other major illnesses. She never had a follow-up for her inserted IUCD. Her systemic examination revealed minimal pallor. She was normotensive. Per abdomen a mass of approximately 14 to 16 weeks size arising from pelvis could be palpable more in left iliac fossa. Per speculum examination did not show IUCD thread. Cervix was unusually pulled up. Bimanual pelvic examination revealed uterus enlarged up to 10 weeks size with a left-sided huge mass of approximately 15 × 15 cm. Pelvic mass was firm in consistency, cervical movements transmitted to the mass. Left ovary was not felt separately. In right adnexa there was a mass of approximately 4 × 4 cm.

Pelvic ultrasound revealed an enlarged uterus with IUCD placed away from the endometrial cavity more in the left cornu and myohyperplasia. There was a hypoechoic mass in left adnexa of size 16 × 15 × 14 cm. Left ovary was not visualized separately. Right ovary was normal as per ultrasound report.

X-ray of pelvis confirmed the presence of IUCD in the pelvis.

The patient and her relatives were counseled for examination under anesthesia and attempt to removal of IUCD via hysteroscopy and dilation and curettage followed by planned laparoscopic surgery or exploratory laparotomy after a week. Due to financial constraints, the patient opted for immediate laparotomy.

After preoperative evaluation, the patient was taken for laparotomy with informed written consent for hysterectomy. The uterus was enlarged due to adenomyosis. A mass was seen arising from the left lateral border of cervix and extending between the broad ligament flaps measuring 15 × 15 cm. Another small mass of around 4 × 3 cm was seen arising from the left border of cervix (Figs 1 and 2). Left ovary was normal. Right ovary was enlarged with evidence of hemorrhagic cyst. Right ovary was adherent to the fallopian tube.

Total abdominal hysterectomy with right salpingo-oophorectomy was performed.

The cut section of specimen revealed an IUCD embedded in the left cornu of the uterus and the thread



Fig. 1: Uterus with cervical fibroid and right ovary



Fig. 2: Intrauterine contraceptive devices thread from the uterine cavity

was intact but pulled inside the uterine cavity due to the enlarged endometrial cavity and a fibroid that was pulling the cervix up. The cut section of cervical mass revealed swirling pattern suggesting a fibroid.

Histopathology confirmed adenomyosis of uterus with cervical fibroid.

DISCUSSION

Although women opt for this relatively safe method of contraception, many lack knowledge about the importance of follow-up and are unaware about the duration of IUCDs to be used.

For many women, even an embedded IUCD may have minimal or no adverse consequences. Thus they fail to attend regular follow-ups and land themselves in some or other health hazard. The most common negative sequelae of women with an embedded IUCD, however, include irregular bleeding and pain in abdomen.

Bernacerraf et al⁵ retrospectively reviewed the medical records of 167 consecutive women who had ultrasound examination with an IUCD in place and found that 28 (16.8%) of them had malpositioned or embedded devices.³ Of these 28 women, 75% presented with either bleeding or pain, compared with 34.5% of women with normally positioned devices.

Postinsertion, women should have follow-up visits as recommended. First, the visit should be at the 1st menstrual period or after 1 month, whichever is earlier. Subsequently, the next visit is after 3 months. Thereafter, once a year for the exclusion of infection, abnormal bleeding, and the proper position of Copper T.⁶

An Intrauterine contraceptive device user should be instructed to contact health care provider in case of: (1) IUCD threads cannot be felt, (2) she or her partner can feel the lower end of IUCD, (3) persistent abdominal

pain, fever, dyspareunia, unusual vaginal discharge, and (4) when she misses periods.⁷

CONCLUSION

This case presented with a missing thread which was pulled up in uterine cavity due to enlarged adenomyosis of uterus with cervical fibroid. Although we cannot avoid a fibroid being developed, but proper follow-up could have prevented patient from the menorrhagia, pain, and in turn embedded IUCD. Whenever we come across such case we should treat the patient extensively. It is equally important to counsel the patient regarding regular follow-ups. She should also be educated about the fact that an IUCD should be removed at the expiration date.

REFERENCES

1. Farooq F, Afridi Z, Farooq MA, Qureshi IA. Urological complications of intrauterine contraceptive device. *JPMI* 2007;21(4):260-265.
2. Cheng D. The IUD: still misunderstood after all these years. *South Med J* 2000 Sep;93(9):859-864.
3. Barsual M, Sharma N, Sangwan K. Three hundred and twenty four cases of misplaced IUCD – a five years study. *Trop Doct* 2003;33:11-12.
4. Lee A, Eppel W, Sam C, Kratochwil A, Deutinger J, Bernaschek G. Intrauterine Device Localization By Three-dimensional Transvaginal Sonography. *Ultrasound Obstet Gynecol* 1997;10:289-292.
5. Bernacerraf BR, Shipp TD, Bromley B. Three-dimensional ultrasound detection of abnormally located intrauterine contraceptive devices which are a source of pelvic pain and abnormal bleeding. *Ultrasound Obstet Gynecol* 2009 Jul;34(1):110-115.
6. Guidelines for IUCD Insertion for Medical Officers. New Delhi: Ministry of Health and Family Welfare, Government of India; 2003.
7. Sowmya K, Shruthi, Manoli N. A case report of successful retrieval of missing Copper T by laparoscopic approach. *J Med Sci Health* 2016;2(1):37-39.