

Perforation of the Rectum by a Copper-T Intrauterine Contraceptive Device with Retrieval per Rectum: A Case Report

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Abstract

Intrauterine contraceptive devices are among the most effective forms of contraceptives available. They provide long term reversible protection from pregnancy and are currently the most popular and widely use reversible contraceptive method. Though they are associated with few side effects, perforation of the uterus remains the most serious. We report the case of a grandmultiparous lady whose copper-IUCD perforated her rectum 8 years after its insertion. We advocate the inclusion of rectal examination in the evaluation of patients for missing IUCDs and removal of the devices per rectum if partially embedded rather than resorting to surgery.

Key Words: Rectum, Perforation, IUCD

Introduction

Intrauterine contraceptive devices (IUCDs) are among the most effective forms of contraceptives available¹. They provide long term yet quickly reversible protection from pregnancy and are currently the most popular and widely used reversible contraceptive method¹. Globally, 13% of all married women of reproductive age use an IUCD and the most popular device is the copper T380A which is also the gold standard².

Modern IUCDs are associated with few side effects. However, those reported include pelvic infection, menstrual complaints, missing IUCDs, ectopic pregnancy, septic abortion and uterine perforation¹. Uterine perforation is one of the least but most serious complication associated with the use of an IUCD³. In about 80% of the perforations, the devices are located freely in the intra-peritoneal space⁴. Erosion into adjacent structures are exceptionally rare events⁴. We report the case of a grandmultiparous lady whose copper-T IUCD perforated her rectum 8 years after it was inserted and was subsequently removed per rectum.

Case Report

Mrs EEE, a 36 year old para 5⁺ 0 midwife was referred from a private clinic on the fourth of October 2008 with complains of feeling the strings of an IUCD in her anus when bathing. She had a copper IUCD inserted in a private clinic

without complications 8 years earlier. Two months after the insertion, she noticed she no longer felt its strings. She then visited another private clinic where following unsuccessful attempts to locate the device, a second IUCD was inserted.

Four months prior to presentation, she felt the strings of an IUCD in her anus while bathing. She went to a private clinic where after an examination was performed, the device in the uterus was removed and she was referred to the teaching hospital. There was no associated menorrhagia, dysmenorrhoea, haematochezia, abdominal pain or diarrhoea. On examination, her general condition was satisfactory and her abdomen was full and soft with no palpable masses or organs. Vaginal examination revealed a normal sized anteverted uterus. The adnexa were normal. On rectal examination, the strings of the IUCD were protruding through the anus and the stem palpated in the lower third of the rectum.

A trans-abdominal ultrasound scan showed normal pelvic findings and no intrauterine device. A plain abdominal X-ray with a uterine

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Figure 1: IUCD Displayed Across the Uterine Sound

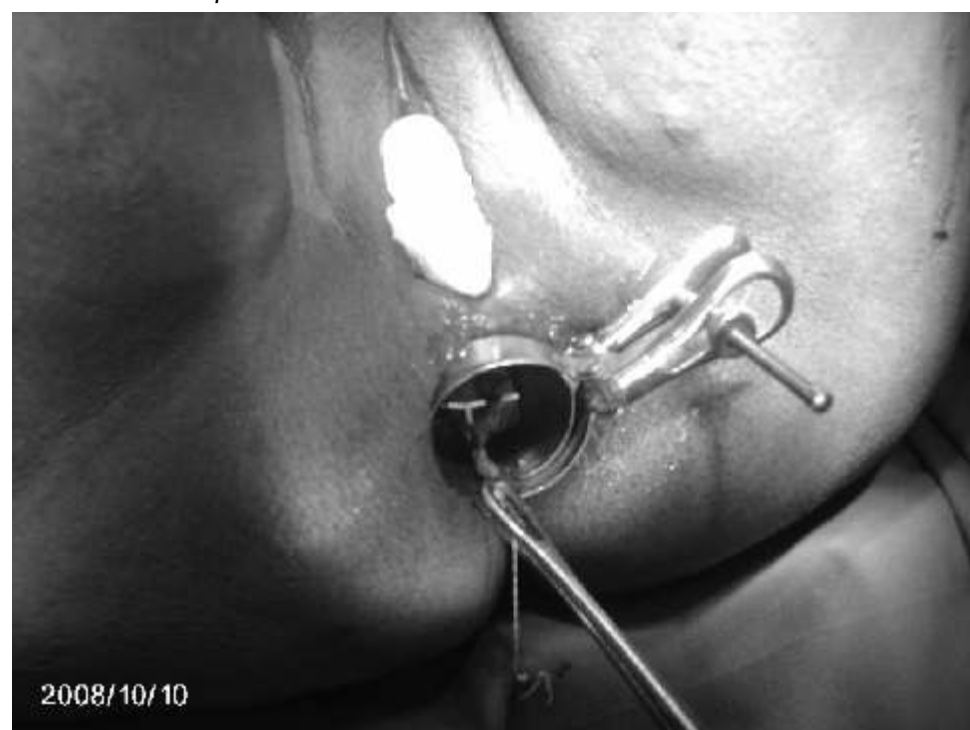


sound inserted showed a copper-T IUCD lying transversely posterior to the sound, outside the uterine cavity and myometrium, subjacent to the rectum. In the anterior-posterior view, the device was projected across the mid portion of

the sound while in the lateral view, the device was posterior to the fundal portion of the uterus (Figure 1).

During examination under anaesthesia, the

Figure 2: IUCD Removed per Rectum



strings and the stem of the IUCD were palpated in the middle and lower third of the rectum while the horizontal arms were felt in the rectal wall posteriorly. Four-finger anal dilatation was done and a Cusco's speculum improvised for an anal speculum was inserted. The copper T IUCD with faecolith completely surrounding its stem was identified, grasped with sponge holding forceps and removed intact (Figure 2). She subsequently had an uneventful postoperative period and was discharged on the third postoperative day.

Discussion

Perforation of the uterus and translocation of an IUCD into the peritoneal cavity though rare remains the most serious complication associated with IUCD insertion⁴. The incidence of uterine perforation varies between 0.5-1.0/1000 insertions². Uterine perforation almost always occurs during insertion of the IUCD and its incidence is related to the timing of insertion, type of device used, the anatomy of the uterus and most importantly the skill and experience of the clinician performing the insertion⁵. Available evidence indicates that only about 15% of perforations lead to complications in adjacent visceral organs principally the intestines, omentum, appendix and bladder³. Perforation of the rectum is reported to be very rare with only a few cases reported in literature and only two of these involving copper-T⁶.

Our patient presented after she felt the strings of

an IUCD in the anus 8 years after its insertion. Though she had visited a health facility when she noticed it was missing, the health provider inserted another IUCD when the first one could not be located probably because it was thought to have been expelled. However, following her presentation in the teaching hospital, a rectal examination revealed the presence of the device and a plain abdominal X-ray with a sound in the cavity of the uterus delineated its extent. The IUCD was then successfully removed through the rectal route. This was probably because the device was partly lying in the lumen and so was easy to grasp and remove with sponge holding forceps. Fistula formation is a potential risk that may follow removal of a partially embedded IUCD by the rectal route. However, inflammatory response and omental adhesions at the site of perforation might have been an important factor in preventing it⁶ from occurring in our patient.

In conclusion, though rare, perforation of the rectum by a translocated copper T IUCD could occur several years after its insertion. Hence, when the strings of an IUCD are missing, the device should be thoroughly sought for and removed particularly if located in the peritoneal cavity. Rectal examination should be an integral component in the evaluation of patients with missing IUCDs and when partially embedded the lumen of the rectum, attempts should be made to retrieve devices per rectum rather than resort to surgery.

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