AN UNUSUAL CASE OF COPPER-T INTRAUTERINE CONTRACEPTIVE DEVICE IN THE URINARY BLADDER.

Lakshmikantha. G, Dwarakanath. L, Chaitra. S. K.

1. Assistant Professor. Department of Obstetrics & Gynecology, Sri Siddhartha Medical College, Tumkur.
2. Associate Professor. Department of Obstetrics & Gynecology, Sri Siddhartha Medical College, Tumkur.
3. Resident. Department of Obstetrics & Gynecology, Sri Siddhartha Medical College, Tumkur.

CORRESPONDING AUTHOR:
Dr. Lakshmikantha. G,
#249, 3rd A Main,
Near Amba Bhavani Circle,
NE of NR Mohalla, Mysore. 570007.
E-mail: drlakshmikanthag@yahoo.co.in
Ph: 0091 9740810611

INTRODUCTION: Intrauterine contraceptive device (IUCD) is the best spacing method of contraception widely practiced all over the world. Although it is widely accepted and a safe procedure of insertion is practiced a rare chance of perforation exists during insertion especially by inexperienced hands. We present a rare case of IUCD found in uterus at 14 weeks gestation which was later found in urinary bladder post delivery.
KEY WORDS: Intrauterine contraceptive device, Copper T, uterine perforation, cystoscopy.

CASE REPORT: 24 years old Para2Live2 presented with an ultrasound report showing Copper T in urinary bladder. Patient gave history that she had got Copper T inserted 2years back at a PHC (primary health centre), 11months after her first normal delivery. A year later she had presented to PHC with 4 months amenorrhoea and was advised scan which showed 14 weeks of intra uterine gestation with copper T in situ. She had continued the pregnancy as per her wish. At term she had delivered vaginally without any complications but Copper T was not found following delivery. Repeat scan at this stage showed copper T in urinary bladder. Patient had no urinary symptoms or pain abdomen. Urine culture showed E Coli. Patient was put on sensitive antibiotics and copper T was removed by cystoscopy subsequently.

DISCUSSION: Intrauterine contraceptive device is the most popular method of reversible contraception due to its high efficacy for fertility regulation, low risk and low-cost. It has been used for over 30 years and is a widely accepted worldwide contraceptive instrument especially in the developing countries. However its use has been associated with some complications namely pelvic inflammatory disease, infertility due to upper genital infections, spontaneous and septic abortion, bowel perforation and vesicouterine fistula and endometrial adenocarcinoma. Other reported complications include dysmenorrhea, hypermenorrhea, pain, pelvic infections, ectopic pregnancy, uterine rupture and migration into adjacent organs (1-6). The mechanism of uterine perforation by IUD may be primarily at the time of insertion (7). It is closely related to the time and technique of insertion, the type of IUD, the skill of the physician, and the anatomy of the cervix and uterus (2). Undetected extreme posterior uterine position is the most common reason for perforation at the time of insertion. This risk increases especially during the puerperium or out of the menstruation, when the uterus is small and its wall is thin predisposing to IUD migration. Inept insertion and position, fragile uterine wall, multiparity,

recent abortion or pregnancy, following cesarean section and sepsis are some of the factors associated with uterine perforation and subsequent transvesical migration (8, 9). Patients may be asymptomatic or may present with abdominal or pelvic pain and lower urinary tract voiding symptoms like recurrent urinary tract infection. These cases underline the need for a closer meticulous post-insertion follow up and a high index of suspicion (9). Secondary perforation can occur by slow migration through the muscular wall of the uterus which can be augmented by spontaneous uterine contractions, urinary bladder contractions (8). Total or partial migration into the bladder usually presents with LUTS as urinary frequency, tenesmus, suprapubic pain, dysuria, hematuria, urinary tract infection, urinary tract obstruction secondary to lithiasis, and urinary incontinence (1,2,5). Persistent or recurrent urinary tract infections are the most frequent presentation, being the diagnosis of intravesical IUD a finding during diagnostic workup . Cystoscopy will confirm the presence of an IUD in the bladder and, it might be possible to retrieve the IUD endoscopically.

Although the management of the migrating IUD in asymptomatic patients remains controversial, no controversy exists about the management of the IUD that migrates into the bladder. All migrated IUDs in the bladder must be removed. Even if the IUD migration is asymptomatic, it should be removed for the prevention of complications such as pelvic abscess, bladder rupture, and adhesions. The most effective treatment remains prevention. The IUD should be correctly inserted by an experienced person. A proper selection of patient and a thorough history and physical examination is crucial. If uterine rupture is suspected, US should be performed to determine the probable location of the rupture. Women should be informed of the potential complications and should be suggested to check the device string regularly. If the string is not found, abdominal radiography is required even in asymptomatic patients.

CONCLUSION: Intra uterine contraceptive Copper T device can be found in urinary bladder either due to faulty insertion or due to perforation and slow migration of the device in to the urinary bladder.

CONFLICT OF INTEREST: None to disclose

REFERENCES:

1. Tunçay YA, Tunçay E, Güzin K, et al. Transuterine migration as a complication of intrauterine contraceptive devices: six case reports. Eur J ContraceptReprod Health Care. 2004;9:194-200.
2. Thomalla JV. Perforation of urinary bladder by intrauterine device. Urology. 1986;27:260-4.
3. Demirci D, Ekmekçioğlu O, Demirtaş A, et al. Big bladder stones around an intravesical migrated intrauterine device. IntUrolNephrol. 2003;35:495-6.
4. Lu HF, Chen JH, Chen WC, et al. Vesicle calculus caused by migrant intrauterine device. AJR Am J Roentgenol. 1999;173:504-5.
5. Grimes DA. Intrauterine device and upper-genital-tract infection. Lancet. 2000;356:1013-9.
6. Dietrick DD, Issa MM, Kabalin JN, et al. Intravesical migration of intrauterine device. J Urol. 1992;147:132-4.
7. Yalçin V, Demirkesen O, Alici B, et al. An unusual presentation of a foreign body in the urinary bladder: A migrant intrauterine device. Urol Int. 1998;61:240-2.

8. Cumming GP, Bramwell SP, Lees DA. An unusual case of cystolithiasis: a urological lesson for gynaecologists. Br J ObstetGynaecol. 1997;104:117-8.
9. Singh I. Intravesical Cu-T emigration: an atypical and infrequent cause of vesical calculus.IntUrolNephrol. 2007;39:457-9.

FIGURE 1-Copper T in urinary bladder