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Case Report

"Lost" and Found, a Case of IUD Migration

Alexander Schlachterman[1]*, Anil Sharma[2] and Eric Hilgenfeldt[3]

[1]*Division of Gastroenterology, Hepatology and Nutrition, Department of Internal Medicine, Thomas Jefferson University, USA*

[2]*University of Florida, Gainesville, Florida*

[3]*Carolinas Medical Center, Charlotte, North Carolina*

***Corresponding Author**: Alexander Schlachterman, Division of Gastroenterology, Hepatology and Nutrition, Department of Internal Medicine, Thomas Jefferson University, USA.

Received: January 02, 2018; **Published:** February 27, 2019

Abstract

Intrauterine device (IUD) perforation is a known, but rare complication of IUD placement in females. Once in the abdominal cavity, IUDs can migrate and potentially perforate surrounding hollow viscus structures. Often, these events are delayed and symptoms may be mild or asymptomatic. This case illustrates an unusual presentation of a lost and found IUD after 28 years with presentation on a routine colonoscopy.

Keywords: *IUD; IUD Migration; Foreign Body; Colonic Perforation*

Abbreviation

IUD: Intrauterine Device

Introduction

An intrauterine contraceptive device (IUD) is a common form of contraception both in the US and worldwide [1]. Modern IUDs are composed of a plastic polymer compound that is copper releasing, progestin releasing or inert. IUDs offer long-acting and reversible contraception that is highly effective, relative low-cost and has an excellent safety profile [2]. The presence of IUDs are becoming more frequent. Despite their safety profile, IUDs are not immune from complications. IUD perforation is estimated to occur as frequently as 3 per 1000 [3]. Therefore, in female patients with an IUD presenting with abdominal pain and discomfort, consideration for potential complications of IUDs as the etiology of their symptoms must be considered as part of the investigation. This case reports a migrated IUD, a rare and potentially morbid complication. The literature review highlights the wide variety in presentation from asymptomatic to severely ill, necessitating a personalized approach utilizing interdisciplinary management.

Case Presentation

A 61-year-old female with a previously normal screening colonoscopy underwent repeat screening colonoscopy. On colonoscopy, a foreign object was noted to jut into the lumen of the large bowel at the level of the sigmoid colon. The foreign object was easily visible as it varied widely from surrounding mucosa. The procedure was aborted and the patient was sent for further imaging. A computed tomography after colonoscopy demonstrated an intrauterine device extending into the sigmoid colon with no surrounding fluid or air to suggest large colonic perforation. On further history gathering, the patient noted having an IUD placed 28 years ago in Uruguay. Gynecologic examination post IUD insertion could not identify the device suggesting asymptomatic spontaneous expulsion. She did not recall having symptoms of abdominal distention, abdominal pain, hematochezia, or nausea and vomiting. This case illustrates an unusual presentation of a lost and found IUD after 28 years with presentation on a routine colonoscopy.

Discussion

The asymptomatic nature of the patient's presentation and denial of currently indwelling IUD made us unaware of IUD migration as a possible cause of her colonic foreign body. However, confirmatory imaging and literature review led us to understand that her asymptomatic presentation was indeed common. A retrospective analysis of 75 patients treated surgically for uterine perforation secondary to migration of an IUD revealed that nearly a third of patients are asymptomatic and those with symptoms often described them as mild [4]. In our patient, it is unclear exactly when the perforation and migration occurred. She reported having a normal screening colonoscopy 11 years prior. Her symptoms and imaging findings suggested that it was not recent (Figure 1). In addition to the asymptomatic presentation, the patient also lacked some of the risk factors associated with increased risk for uterine perforation from an IUD. In a retrospective analysis of 34 patients with IUD migration, pain during insertion of the IUD (70.5%), history of cesarean section (58.8%), insertion in the puerperal period (44.2%) and non-obstetric specialist insertion (85.3%) was implicated as potential predictors for perforation [5].

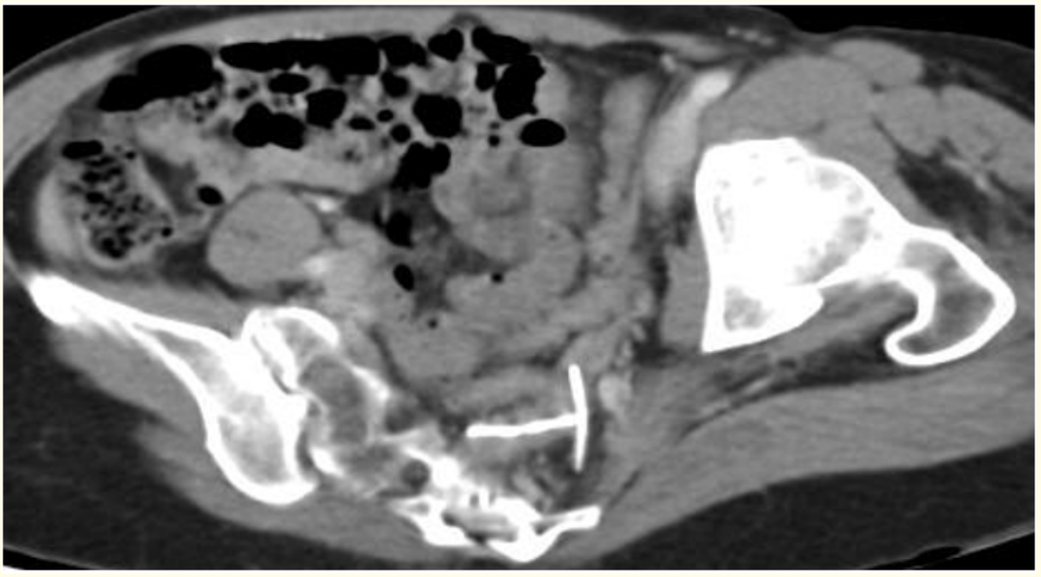

Figure 1: *Malpositioned intrauterine device that appeared to be in close proximity to the sigmoid colon with no surrounding fluid or air to suggest a colonic perforation.*

Perhaps the most intriguing part of our case is of course fact that the IUD was found on a screening colonoscopy (Figure 2). For review, her IUD must have initially perforated the uterus followed by intra-abdominal migration and eventual colonic perforation. A retrospective analysis of 27 patient's by a group in Turkey found that of the 27 IUDs that had migrated into the intra-abdominal cavity, a third where found within the omentum [6]. Other locations of migrated IUDs have been the bladder, left inguinal region and abdominal wall [6-8]. Cases of IUD migration into the bowel have been reported [9,10] but amongst typically reported sites, bowel perforation accounts for less than 10% of cases [11].

Figure 2: *Foreign body perforating the colon at the level of the sigmoid.*

Most studies to date evaluating IUD migration have been retrospective analyses, case series and case reports. The majority of cases of IUD migration necessitate surgical removal, which can often be completed laparoscopically without need for conversion to open surgery [7,9,12,13]. This is highly dependent on the location of IUD migration of course.

Conclusion

The common form of contraception, intrauterine contraceptive device (IUD) is highly effective, relative low-cost and has an excellent safety profile [2]. The presence of IUDs are becoming more frequent. Despite their safety profile, IUDs are not immune from complications. This case reports a migrated IUD, a rare and potentially morbid complication. The literature review highlights the wide variety in presentation from asymptomatic to severely ill, necessitating a personalized approach utilizing interdisciplinary management. Our patient's colonoscopy revealed a foreign object perforating the sigmoid colon. The procedure was aborted and the patient had a CT. This case illustrates an unusual presentation of a lost and found IUD after 28 years. Cases of IUD migration into the bowel have been reported [9,10] but amongst typically reported sites, bowel perforation accounts for less than 10% of cases [11]. The asymptomatic nature of the patient's presentation and denial of currently indwelling IUD made us unaware of IUD migration as a possible cause of her colonic foreign body. However, confirmatory imaging and literature review led us to understand that her asymptomatic presentation was indeed common. Educating the medical community of an abnormal presentation of a migrated IUD is necessary in preventing future missed diagnosis and treatment.

Conflict of Interest

The author of this article has no financial interest or any conflict of interest exists to declare.

Bibliography

1. Buhling KJ., *et al*. "Worldwide use of intrauterine contraception: a review". *Contraception* 89.3 (2014): 162-173.

2. Heinemann K., *et al*. "Comparative contraceptive effectiveness of levonorgestrel-releasing and copper intrauterine devices: the European Active Surveillance Study for Intrauterine Devices". *Contraception* 91.4 (2015): 280-283.

3. Harrison-Woolrych M., *et al*. "Uterine perforation on intrauterine device insertion: is the incidence higher than previously reported?" *Contraception* 67.1 (2003): 53-56.

4. Kaislasuo J., *et al*. "Uterine perforation caused by intrauterine devices: clinical course and treatment". *Human Reproduction* 28.6 (2013): 1546-1551.

5. Agacayak E., *et al*. "Evaluation of predisposing factors, diagnostic and treatment methods in patients with translocation of intrauterine devices". *Journal of Obstetrics and Gynaecology Research* 41.5 (2015): 735-741.

6. Adiyeke M., *et al*. "Surgical management of intrauterine devices migrated towards intra-abdominal structures: 20-year experience of a tertiary center". *Clinical and Experimental Obstetrics and Gynecology* 42.3 (2015): 358-360.

7. Aghaways I., *et al*. "Migration of an intrauterine device to the left inguinal region, the first reported case". *International Journal of Surgery Case Reports* 28 (2016): 68-70.

8. Dimitropoulos K., *et al*. "Intrauterine device migration to the urinary bladder causing sexual dysfunction: a case report". *Hippokratia* 20.1 (2016): 70-72.

9. Rahnemai-Azar AA., *et al*. "Laparoscopic removal of migrated intrauterine device embedded in intestine". *JSLS* 18.3 (2014).

10. Eichengreen C., *et al*. "Rectal perforation with an intrauterine device: a case report". *Contraception* 3 (2015): 261-263.

11. Gill RS., *et al*. "Laparoscopic removal of an intra-abdominal intrauterine device: case and systematic review". *Contraception* 85.1 (2012): 15-18.

12. Voulgaris AM., *et al*. "The case of the migrating IUD". *Practitioner* 259.1788 (2015): 25-27.

13. Uçar MG., *et al*. "Management of intra-abdominally translocated contraceptive devices, is surgery the only way to treat this problem?" *Journal of Obstetrics and Gynaecology* 37.4 (2017): 480-486.

Volume 8 Issue 3 March 2019