

The Unusual Case of a Copper T Migrating to the Ovary

Aritra Maji¹, Aditi C Ramachandra²

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¹Assistant Professor, ²Senior Resident, Department of Obstetrics and Gynecology, MVJ Medical College and Research Hospital, Bengaluru, Karnataka 562114, India.

Corresponding Author: Aditi C Ramachandra, Senior Resident, Department of Obstetrics and Gynecology, MVJ Medical College and Research Hospital, Bengaluru, Karnataka 562114, India.

E-mail: aditicr@gmail.com

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Abstract

Extrauterine migration of like Copper T is an well reported complication of intrauterine contraceptive device, most of the times occurring at the time of insertion. Migration of Copper T into the peritoneal cavity can present as acute abdomen. Common sites of migration of IUCD are bladder, rectosigmoid. However migration of Copper T in the ovary is an extremely rare event. Here is a case of a 23 year old pregnant lady with intrauterine gestation of 11+2 weeks associated with migration of IUCD into the ovary. The approach was exploratory laparotomy, on which Copper T was seen completely embedded with right ovary, followed by safe removal of the IUCD while conserving the ovary. Hence, to conclude careful insertion of Copper T by trained hand and patient education regarding missing thread is of utmost importance to reduce untoward complications of IUCD.

Keyword: Contraceptive; Peritoneal; Bladder; Rectosigmoid; Gestation; Laparotomy; Ovary; IUCD; Cu-T.

Background

Intrauterine Copper T devices are a safe and effective form of contraception which is easily accepted by the public as a form of long term reversible contraceptive. On of the most serious

uncommon complications include perforation of the uterus (0.4-1.6 per 1000 insertions) which most frequently occurs at the time of insertion. Perforation might lead to migration of the Cu-T to adjacent organs more commonly like bladder, rectosigmoid. There have been very few case reports of Cu-T migrating to the ovary.

Case history

A 23 year old pregnant woman G2P1L1 with 11 weeks 2 days period of gestation presented in our OPD with a history of contraceptive failure. When she had a history of 3 months of amenorrhoea she did a urine pregnancy test which was positive. On retrospective questioning she gave history of insertion of Cu-T one year ago. However she did not periodically check for the Cu-T thread. Patient had a full term vaginal delivery 3 years ago with no complications. Patient was otherwise asymptomatic. General physical examination was normal. Abdomen was soft and non tender. On per speculum examination Cu-T thread was not visible through the external os. Per vaginal examination revealed a gravid uterus with no tenderness. Ultrasonography of abdomen and pelvis revealed gravid uterus of 11 weeks 5

days gestation with Cu-T placed inside the right ovary which was complimented by MRI. Patient requested for termination of pregnancy along with removal of ectopic Cu-T. Hence dilatation and evacuation with explorative laparotomy was planned. After evacuating products of conception explorative laparotomy was proceeded. Right ovary was enlarged and hard. Horizontal arm was felt of the posterior-medial surface of the right ovary. The Cu-T was completely embedded within the ovary with protrusion of one end of the horizontal arm which was grasped with an artery forceps and slowly pulled out (Fig. 1). Cu-T was removed in toto and then lacerated margin of ovary (Fig. 2) was cauterized to achieve hemostatic control (Figure 3a and 3b). Left ovary was normal. On closer inspection of the uterus the rightfundo- lateral wall was found to have a healed scar of approximately 2 cms (Fig. 4). The abdomen was then closed after securing hemostasis. Post operative period was uneventful and she was discharged on 5th post operative day.

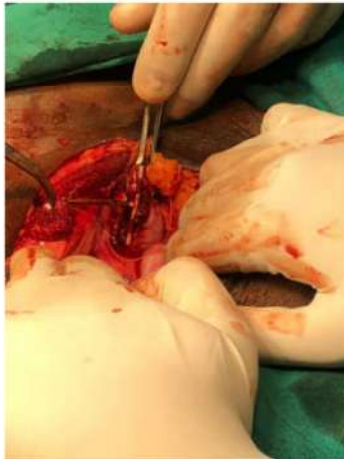


Fig. 1:



Fig. 2:



Fig. 3a:

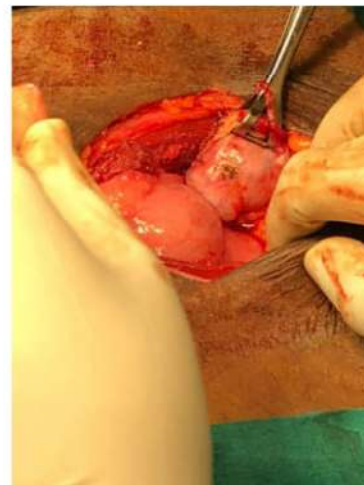


Fig. 3b:



Fig. 4:

Discussion

There are various methods offering reversible contraception but Copper IUCD is the most popular one as it is safe, reliable and economical. Risk factors for the use include nulligravida, post partum insertion, irregular follow up and lack of education regarding checking of the thread periodically [1].

Factors such as inert positioning, fragility of uterine wall due to recent birth, abortion, and pregnancy are contributory to the possibility of uterine perforation [2]. After perforating the uterine wall the copper T IUCD can migrate to the Colon, wall of the iliac vein, bladder, appendix, colon, omentum, pouch of Douglas and ovary [3,4,5,6].

Regular self-examination, investigation of persistent pain, or disappearance of strings may detect migration early [7].

Although management of a migrated IUD in an asymptomatic patient is controversial, there appears to be a consensus that all extrauterine devices should be removed unless the patient's surgical risk is excessive [8,9,10].

Conclusion

Healthcare workers must be aware of potential complications with respect to perforation and appropriate measures should be taken to prevent perforation especially at the time of insertion. Patients must be educated about checking Copper T threads and the implications of a missing thread. If uterine perforation is confirmed then surgical management should be undertaken immediately to prevent any untoward effect.

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