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Research Article

**THIRTY YEARS OLD FEMALE'S IUD (INTRAUTERINE  
DEVICE) TRANSMIGRATION INTO THE SURGICAL  
MANAGEMENT OF SIGMOID COLON**<sup>1</sup>Dr Faiza Naeem, <sup>2</sup>Dr Rabia Ghulam Sakeena, <sup>3</sup>Farman Ullah Khan<sup>1</sup>BHU 81/5R, WMO, <sup>2</sup>BHU 1/10L, WMO, <sup>3</sup>BHU Sandanwala, Piplan, Mianwali**Article Received:** December 2018**Accepted:** February 2019**Published:** March 2019**Abstract:**

The current research study was carried out on the female of 30 years at Jinnah Hospital, Lahore (September 2017 to January 2018). She was suffering from disturbed bowel habits and abdominal discomfort. Before five years, she had an Intrauterine device place in a delicate uterus. There was a possibility of translocated IUD. It was due to the reason that on gynaecological assessment, pulling out of IUD strings was unsuccessful. On CT abdomen and colonoscopy, its ectopic placement was ensured in the sigmoid colon. Laparotomy was carried out for removing transmigrated IUD.

**Keywords:** Intrauterine Device, Sigmoid Colon, Case Report.**Corresponding author:****Dr. Faiza Naeem,**  
BHU 81/5R, WMO.

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**INTRODUCTION:**

For suitable management of birth, intrauterine contraceptive devices are commonly used. The percentage of their occurrence in developed countries and developing countries is 9.4% and 16.5% respectively [1]. Iatrogenic or secondary abrasion of the uterine wall is a serious complication of an intrauterine device. This complication is very

uncommon. 1.3 per 1000 causes encountered this complication [2]. Along with the potential morbidities of bowel perforation, adhesion and fistula formation, this could hardly indicate the conversion of IVD into abdominal viscera [3, 4]. In this study, the case of ectopic LUD in sigmoid colon is presented. It was removed through surgery.



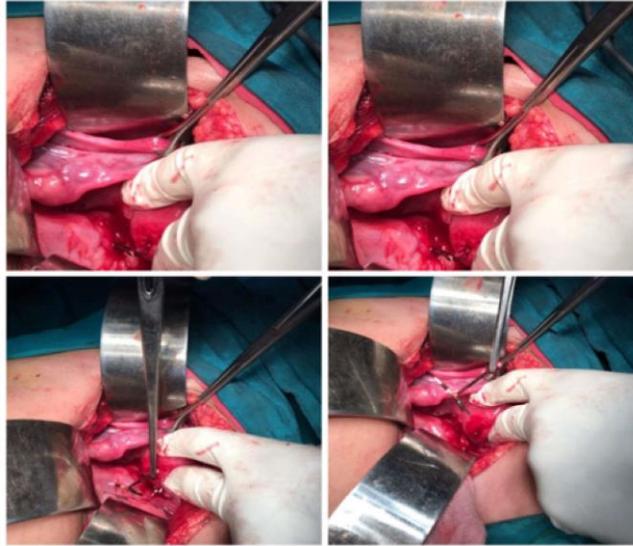
**Figure – I:** (Upper Left image: shows colonoscopy view of the stem of IUD in the lumen of sigmoid colon), (Upper right image: shows an IUD in the pelvis in an X-ray abdomen erect film), (Bottom image: CT abdomen and pelvis with contrast showing transmigrated stem of IUD).

**CASE REPORT:**

In this report, a case of 30 years old female is discussed. She was suffering from recurrent variations in bowels habits and a dull ache in the lower abdomen for one year. Before five years in puerperium, an intrauterine contraceptive device is placed in patients following her third spontaneous vaginal delivery. Patients were abdominally assessed and found with left iliac fosse more pronounced in hypogastrium and mild and tender men. No history of burning micturition, weight mass, vaginal discharge or menstrual irregularities was found in patients. Threads of IVD were observed on per speculum assessment. But they were failed to pull out with forceps. All the baseline including ESR were investigated which were normal. Empirical antibiotic therapy was employed for

the management of the patients. One horizontal arm of IUD eroding the uterine wall is shown by transvaginal ultrasound. On the other hand, IUD is illustrated by a plain erect radiographic abdomen. Almost 15 from the same verge a metallic body penetrating the colonic wall is illustrated by colonoscopy. An elective laparotomy was planned for the purpose of surgical rectification of IUD. For a small amount of reactionary fluid and adhesion, intraoperative calculation was important. Colonic perforation was repaired primarily and IUD was removed. It was done by following adhesiolysis. Before the operation patients were admitted in a high dependency unit. After four days of operation, patients were sent home and was healthy.

**IUD:** Intrauterine device.

**Figure – II:** Surgical removal of the transmigrated intrauterine device from sigmoid colon**DISCUSSIONS:**

Uterine perforation is being of serious complexities of IUD insertion. This complexity may occur at the time of placement or after placement when uterine concentration embeds IUD in the uterine wall. In 15% of the cases, it encourages its migration into abdominopelvic organs [5]. These organs include sigmoid, bladders small bowel appendix and rectum [6]. History of abortion, insertion in puerperium period congenital uterine anomalies and insufficiency of clinician skills are some risk factors that make vulnerable transmigration of the intrauterine device [7]. A serious complication is offered by these ectopic intrauterine devices. These complications include peritoneal adhesion bowel perforation fistula formation volvulus and bowel obstruction [4]. Missing IUD strings on per speculum vaginal assessment, vaginal discharge, burning micturition [6], clinical spectra of peritonitis chronic lower abdominal discomfort and undesired conception are some of the sign and indications of transmigrated IUD. In our cases predisposing risk factors were retroverted uterine axis, insufficient IUD follow up and insertion in the puerperium. However, bowel injury was suggested by the inability to pull out IUD strings, altered bowel habits and chronic pelvic pain due to IUD. The hypoechoic impression is given by the copper-containing intrauterine devices. On the other hand, levonorgestrel releasing intrauterine devices contain barium sulphate so they are not visible on ultrasonography [7]. Radiopaque on plain X-rays film of the abdomen is the copper-containing IUD [8]. In order to assess the complexities of translocated

intrauterine devices in abdomens and exact location, a contact enhances computed tomography of abdomens should be the consideration of choices [9]. In order to remove misplaced IUD, minimally invasive methods should be employed. Cystoscopy colonoscopy and hysteroscopy are some of those methods. The percentage of cases were recovered by minimally invasive techniques were 93% whereas, the percentage of cases of translocated LUDs with abdominal viscera perforation were 57% among the cases is misplaced intrauterine devices mentioned so far [10].

**CONCLUSION:**

Clinicians of colonic embedment of IUD should be attentive through the history of chronic pelvic discomfort with changes in bowel habits and failure of retrieving intrauterine device by pulling out its strings. In case of full-thickness colonic perforation by misplaced LUD, the open surgical method should be employed. Moreover, there is infrequent transmigration of the intrauterine device to abdominopelvic viscera.

**REFERENCES:**

1. Boortz HE, Margolis DJ, Raghavendra N, Patel MK, Kadell BM. Migration of intrauterine devices: radiologic findings and implications for patient care. *Radiographic*. 2012; 32:335-52.
2. Bozkurt M, Yumru AE, Coskun EI, Ondes B. Laparoscopic management of a translocated intrauterine device embedded in the gastric serosa. *J Pak Med Assoc*. 2011; 61: 1020-2.

3. Arslan, M Kanat-Pektas, H Yesilyurt, U Bilge. Colon penetration by a copper intrauterine device: a case report with literature review. Arch Gynecol Obstet. 2009; 279: 395-7.
4. FR Mosley, N Shahi, MA Kurer. Elective surgical removal of migrated intrauterine contraceptive devices from within the peritoneal cavity: a comparison between open and laparoscopic removal. JSLS. 2012; 16:236-41.
5. A Weerasekera, P Wijesinghe, W Nugaduwa. Sigmoid colocolic fistula caused by intrauterine device migration: a case report. J Med Case Rep. 2014; 81.
6. D G Shin, T N Kim, W Lee. An intrauterine device embedded into the bladder wall with stone formation: laparoscopic removal is a minimally invasive alternative to open surgery. Int Urogynecol J. 2012; 23: 1129-31.
7. United Nations, World Contraceptive Use 2007, United Nations. New York: Population Division, Department of Economic and Social Affairs, 2008.
8. Heinberg EM, McCoy TW, Pasic R. The Perforated Intrauterine Device: Endoscopic Retrieval. JSLS. 2008; 12: 97-100.
9. Sinha M, Gupta R, Tiwari A. Minimally invasive surgical approach to retrieve migrated intrauterine contraceptive device. Int J Repro Contracept Obstet Gynecol. 2013; 2: 147-51.
10. Inceboz US, Ozcakir HT, Uyar Y, Calar H. Migration of an intrauterine contraceptive device to the sigmoid colon: a case report. Eur J Contracept Reprod Health Care. 2003; 8: 229-32.