



A Very Rare Complication after Removal of Intrauterine Device: Multiple Intestinal Rupture

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Abstract

Intrauterine device, it may cause various Complications during and after insertion or removal. In this case report IUD.

Introduction

The use of Intrauterine Device (IUD) for birth control is increasing in women. This is because IUD is an effective and reliable method. It is one of the most frequently used methods in our country. Approximately 5.3% of the US is used by women [1].

IUD-induced uterine perforation is an extremely rare but very serious complication. Asymptomatic pain, abnormal bleeding, bowel or bladder perforation, such as fistula formation can cause a variety of complications.

In this case report, we wanted to refer to a patient who underwent intestinal perforation and presented with acute abdomen and underwent successful surgical intervention while attempting to remove IUD.

Case Presentation

A 49-year-old female patient was admitted to our outpatient clinic with complaints of abdominal pain and nausea. The patient was informed that IUD was inserted for birth control 4 years ago and the patient was tried to remove the IUD at the external center before the procedure, but the procedure was unsuccessful. Physical examination did not show IUD. Menstrual spotting was present. There was rebound and tenderness with deep palpation in the abdomen. Abdominal ultrasonography: 6 cm in the right ovary. Left ovary 2 cm. endometrioma was in the IUD cavity; pelvic fluid. There was a suspicion of uterine rupture. In the clinical follow-up of the patient, emergency abdominal tomography was performed because of worsening of general condition, increased pain and development of acute abdomen. Tomography; Common free air views adjacent to the anterior wall of the abdomen are monitored, free air fluid level around the liver. There are widespread free air views inside the abdomen and free fluid appearances (including air images). The free fluid appearance is more pronounced in the pelvic area, especially in the left parauterine level. In the foreground, perforation is considered. There is IUD in the endometrial cavity. Approximately 6.5 cm in the right adnexal area internal density was reported as increased cystic appearance (hemorrhagic cyst? and endometrioma?) (Figure 1,2). The patient underwent laparotomy with general surgery under emergency conditions. The abdomen was opened with six median incisions. It was seen that there was too much intestinal content in the abdomen. In the exploration, the ileocecal valve was approximately 60 cm. proximal to ileum, small intestinal wall, 2 close perforations were seen. In addition, approximately 150 cm distally from the treitzden again approximately 0.5 cm in the intestinal wall, perforation was observed (Figure 3). One piece of 0.5 cm hole in diameter (Figure 4), other bowel and colon segments were intact. Treitzden 150 cm the distal perforation was primary sutured with 3/0 silk. The perforated segment was removed from the left lower quadrant with a loop ileostomy and the perforation mouths were joined and the mouth was cut to the skin. After bleeding control, the floors were closed properly. The patient was transferred to general surgery for follow-up.

Discussion

We did not find any uterus and then multiple intestinal perforations after failed IUD removal. In this respect, we think our case is different.

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Received Date: 01 Oct 2018

Accepted Date: 18 Oct 2018

Published Date: 22 Oct 2018

Citation:

Günday ÖK. A Very Rare Complication after Removal of Intrauterine Device: Multiple Intestinal Rupture. *World J Surg Surgical Res.* 2018; 1: 1069.

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Figure 1: Air fluid levels in the abdomen.

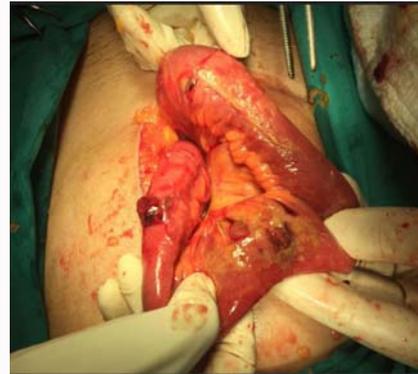


Figure 3: Multiple perforations in intestines.

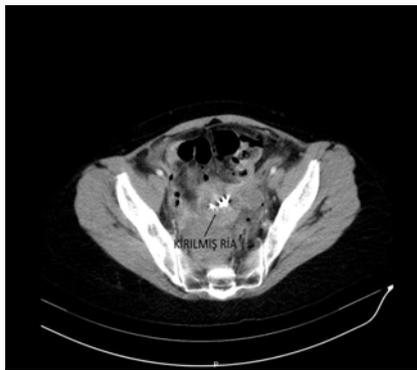


Figure 2: IUD broken in myometrium.



Figure 4: Damage in bowel and intestine.

IUD is a reversible, long-acting, cost-effective method of birth control [2]. Copper, silver, steel, such substances are available. Although there is no consensus on the mechanism of action, it is thought to affect fertilization and/or implantation by inflammation.

The incidence of uterine perforation due to the intrauterine contraceptive device is estimated to be 1/1000 [2]. Risk factors for uterine rupture have been reported as breastfeeding, postpartum, uterine anomaly, adenomyosis and lack of experience of the wearer [3-5]. It is usually recommended to wear it after the 6th month after delivery [6]. Thinning of the postpartum uterus wall is the main reason for this. In addition, the contractions in this period should not be forgotten.

If intestinal perforation occurs after uterine perforation, the perforation site is most frequently the small intestine, rectum and sigmoid column. IUD may be partially or completely embedded in the intestinal wall [7]. Perforation may be asymptomatic, or a catastrophic result, such as an acute abdomen, may be encountered in our case.

Lost IUD is understood by the absence of ropes. Ultrasonography is the first choice in diagnosis. Easy, reliable and non-invasive also allows us to understand whether the IUD is in the endometrial cavity. In cases where IUD is not seen in the cavity, CT can benefit from magnetic resonance imaging. As a very simple method, it can be understood whether it is in the abdomen by direct abdominal radiography. In addition, hysteroscopy is a safe, non-invasive, effective and inexpensive diagnostic method in the removal of IUDs that are not rope and embedded in the cavity [8,9].

Diagnosis should be treated with antibiotics to prevent pelvic

inflammation and should be removed. Lost IUDs should be removed even if they are asymptomatic. Because of obstruction in the intestines, adhesion, inflammation, perforation and pain in the organs of the environment may be the cause.

In the treatment, colonoscopic, laparotomic or laparoscopic methods can be used for the diagnosis and treatment of IUD and its possible complications. But it is not suitable for every case. The general condition of the patient, laboratory findings, hemodynamics should be guiding. If there is sepsis and intestinal perforation, laparotomy should be preferred. We also performed laparotomy in order not to lose time because of the bad condition of our patient, the development of acute abdomen findings and the suspicion of serious bowel perforation. And after seeing the painting, we realized how righteous we were.

As a result, although IUD removal is seen as a simple procedure, it is appropriate to remove non-rope and intrauterine buried IUDs with ultrasonography or hysteroscopy. Blindness interventions during removal may cause IUD to break, exceed the myometrium wall and cause damage to the surrounding organs. In cases where it cannot be removed, close clinical follow-up and hysteroscopy should be determined if necessary.

References

1. United Nations. Population Division, Department of Economic and Social Affairs. World contraceptive use 2010.
2. Peterson H, Curtic K, Meirk O, D'Arcargues C. Contraception. In: Scott JR, Gibbs RS, Karlan BY, Haney AF, editors. Danforth's Obstetrics and Gynecology. 9th ed. Philadelphia: Lippincott Williams & Wilkins, 2003:541-61.

3. Andersson K, Ryde-Blomqvist E, Lindell K, Odland V, Milsom I. Perforation with intrauterine devices. Report from a Swedish survey. *Contraception*. 1998;57(4):251-5.
4. Harrison-Woolrych M, Ashton J, Coulter D. Uterine perforation on intrauterine device insertion: is the incidence higher than previously reported? *Contraception*. 2003;67(1):53-6.
5. Caliskan E, Oztürk N, Dilbaz BO, Dilbaz S. Analysis of risk factors associated with uterine perforation by intrauterine devices. *Eur J Contracept Reprod Health Care*. 2003;8(3):150-5.
6. Heartwell SF, Schlesselman S. Risk of uterine perforation among users of intrauterine devices. *Obstet Gynecol*. 1983;61(1):31-6.
7. Gill RS, Mok D, Hudson M, Shi X, Birch DW, Karmali S. Laparoscopic removal of an intra-abdominal intrauterine device: case and systematic review. *Contraception*. 2012;85(1):15-8.
8. Fuentes JA, Hernández MA. Of office hysteroscopy for the removal of intrauterine device. Literature review. *Ginecol Obstet Mex*. 2009;77(4):197-201.
9. Di Spiezio Sardo A, da Cunha Vieira M, Scognamiglio M, Zizolfi B, Nappi C, de Angelis C. The Challenging Intrauterine Contraceptive: In-office Hysteroscopic Approach. *J Minim Invasive Gynecol*. 2016;23(4):469.