

The case of the migrating IUD

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Mr Athanasios M Voulgaris
MD MFEBU PhD
Urology Senior Clinical Fellow

Dr Tiffany Lee
MB ChB
FY1 Urology

Mr Abhul Habib
MB BS
Urology Specialty Doctor

Mr Rajesh Kavia
MB BS FRCS FRCS(Urol)
Consultant Urological Surgeon

Northwick Park Hospital, London North West NHS Trust, Harrow, Middx, UK



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AUTHORS

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FIGURE 1

Flexible cystoscopy revealed the presence of an IUD within the bladder

What symptoms raise suspicion of a dislocated IUD?



THE INTRAUTERINE CONTRACEPTIVE DEVICE (IUD) IS CONSIDERED TO BE THE MOST POPULAR

method of reversible contraception in developed countries because of its safety, efficacy and low cost.

One significant, but uncommon, complication is uterine perforation during or after insertion. A recent large, prospective cohort study reported an incidence of 1.1-1.4 per 1,000 insertions.¹

IUDs are not always inserted by healthcare professionals with the requisite skills and experience and follow-up after IUD insertion does not always take place.

How should patients be investigated?

As a result IUDs may be forgotten, lost or misplaced. In this report, we present a case in which an IUD migrated to the bladder.

‘The body of the IUD had become embedded in the bladder wall’

CASE REPORT

A 30-year-old lady presented to the gynaecologist with persistent vaginal bleeding following insertion of an IUD.

How can potential complications be prevented?

At the time, abdominal examination was unremarkable and speculum examination revealed normal external genitalia and cervix.

A transvaginal ultrasound showed a normal uterus, normal ovaries and no adnexal masses or free fluid. It was assumed that the IUD had fallen out.

Around the same time she presented to her GP with a short history of dysuria, intermittent visible haematuria and recurrent urinary tract infections (UTIs).

After initial management in general practice for 12 months, she was referred to the urology department for further investigation.

She underwent flexible cystoscopy, »

CASE REPORT

IUD MIGRATION

which demonstrated the presence of an IUD within the bladder. Under general anaesthesia, we found that the body of the IUD had penetrated the bladder mucosa and become embedded in the right lateral wall of the bladder.

The IUD was markedly calcified but was easily removed endoscopically as a whole unit with grasping forceps.

A three-week postoperative cystogram ruled out the presence of a fistula. At the six-week postoperative review she was asymptomatic and well.

DISCUSSION

The Faculty of Sexual and Reproductive Healthcare (FSRH) has recently updated its guidance on intrauterine contraception (see box 1, above).²

The exact mechanism that causes uterine perforation and migration of an IUD is not entirely understood. There are two main mechanisms of uterine perforation suggested.

The first occurs at the time of insertion. It is associated with severe abdominal pain and is closely related to the time and technique of insertion, the type of IUD, the skill of the clinician, and the anatomy of the cervix and uterus. The most significant factor implicated is operator experience.

The second proposed mechanism is by gradual pressure necrosis of the

Box 1

The Faculty of Sexual and Reproductive Healthcare (FSRH) guidance²

A routine follow-up visit can be advised after the first menses following insertion of an IUD or 3-6 weeks later to exclude infection, perforation or expulsion.

Women should be informed about signs and symptoms of infection, perforation and expulsion and how to check the threads, and advised to return if they have any problems.

If there is any possibility of perforation at the time of insertion or later, an ultrasound scan and then, if indicated, a plain abdominal and pelvic X-ray should be arranged as soon as possible in order to locate the device. Women should be advised to use additional contraceptive precautions in the interim.

uterine wall by the IUD with migration out of the uterus.

Pregnancy may contribute to the erosion of the uterine wall by an IUD.

‘Every woman with recurrent UTIs should undergo urinary tract imaging’

Alternatively, an IUD in the bladder can be the consequence of inserting it erroneously through the urethra.

Patients may be asymptomatic and the migrated device detected during investigations for other reasons.

Symptoms of a dislocated IUD are non-specific and include dysuria, suprapubic pain, irritative bladder symptoms and recurrent UTIs.

Every woman who has recurrent UTIs should undergo urinary tract imaging.

A migrated intravesical IUD could eventually become either partially encrusted or could instigate calculus formation.

However, secondary bladder stone formation is very uncommon. Karsmakers and colleagues reported a case of a significant calculus formation around a migrated IUD, which created a vesicovaginal fistula causing urinary incontinence and recurrent UTIs, contributing to terminal kidney failure.³

‘Cystoscopy allows simultaneous confirmation of the diagnosis and retrieval of the foreign body’

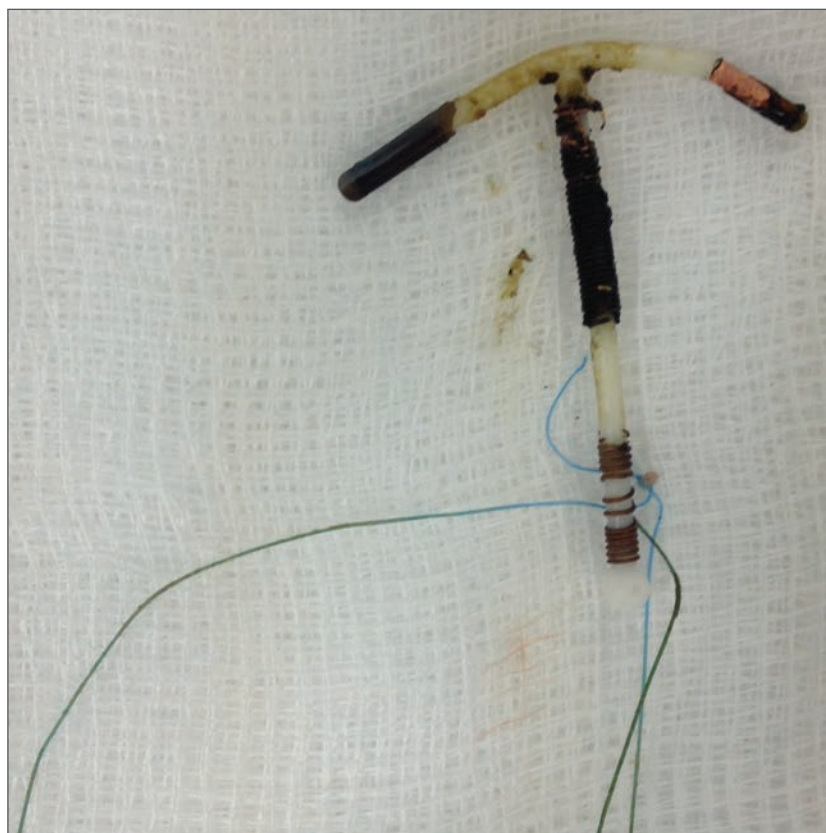
The presence of an intravesical calculus against the background of an IUD insertion should always raise the suspicion of a migrated device.

A secondary hysterosalpingography in order to define the relation between the uterus and the IUD is a diagnostic option but it restricts the option for its simultaneous removal.⁴ Cystoscopy offers the advantage of simultaneous confirmation of the diagnosis and retrieval of the foreign body.

The most effective management is still prevention. All migrated IUDs should be removed even if asymptomatic in

FIGURE 2

The IUD was removed endoscopically as a whole unit with grasping forceps



order to prevent potential complications.

The most common reported procedure used to remove an intrauterine IUD is cystoscopy. Suprapubic cystotomy and open surgery may be required in cases of large stones surrounding the IUD making it difficult to extract endoscopically.

A less common method is intracorporeal lithotripsy and IUD extraction.

CONCLUSION

Although it is very rare, this case highlights the possibility of late uterine perforation and migration of an IUD.

Every symptomatic woman, even during pregnancy, with a history of IUD use should alert the clinician to the possibility of total or partial migration of the device.

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Useful information

Faculty of Sexual and Reproductive Healthcare Clinical Guidance
www.fsrh.org/pdfs/CEUGuidanceIntrauterineContraception.pdf

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800 Guillat Avenue, Kent Science Park,
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