

Displaced Intra-Uterine Contraceptive Device Causing Severe Menorrhagia

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Abstract

The intrauterine contraceptive device (IUCD) is a common method of contraception in developing countries. Expulsion/displacement is a common complication of its use, occurring in 2-8 % of users per 100 women years. Two cases of menorrhagia resulting from displacement of Copper-T-380 IUCD to the cervical canal were presented. The diagnosis was made by simple gentle speculum examination of the vagina and confirmed in one case with ultrasonography. The IUCD was pulled out with an artery or sponge forceps and the bleeding stopped. Awareness of this possible complication and simple speculum examination in any woman wearing an IUCD and presenting with vaginal bleeding or menorrhagia is advocated to avert undue morbidity.

Key Words: IUCD, Displacement, Expulsion, Menorrhagia

Introduction

The intrauterine contraceptive device (IUCD) is the commonest method of contraception in developing countries^{1,3}. About 85 million people use it worldwide². Efforts are continuously being made to modify the IUCD to reduce the complications associated with its use which includes pelvic pain, pelvic inflammatory disease, menorrhagia, irregular vaginal bleeding, and displacement/expulsion^{1,4,5}.

The incidence of expulsion/displacement of IUCD of 2-8 % per 100 women years has been variably reported^{1,4}. The risk factors for displacement of IUCD include immediate post partum insertion, insertion less than six weeks post partum, low parity, poor skill of the operator, type of IUCD, and insertion during lactation⁶. The multi-load type is associated with lowest risk of displacement². We present two cases of menorrhagia resulting from displacement of copper T 380 IUCD to the cervical canal.

Case Reports.

Case 1

Mrs. CN was a 34 year old multiparous woman who presented to the out patient clinic of Life Specialist Hospital with a 19-day history of vaginal bleeding. She used 4 sanitary pads everyday and complained of associated colicky abdominal pains, weakness and breathlessness on exertion.

She had a copper T intra-uterine contraceptive device (IUCD) inserted in November 2001, six weeks after her last confinement. There had been no problem with the device prior to the onset of this episode of prolonged bleeding. She was Para 4⁺. All the deliveries were normal vaginal delivery. Prior to presentation, she had been treated in a primary health care centre with a single dose of intramuscular hydroxyl-progesterone caproate,

intramuscular Vitamin K injection and oral haematinics, but the bleeding had persisted.

Examination revealed an obese woman who was pale and weighed 103kg. Abdominal examination revealed no abnormality. Vaginal speculum examination showed clots of blood in the vagina and bleeding from the cervical os. IUCD tail was in-situ and the tip of the copper T was sited at the external os. Her haematocrit was 20%. Transvaginal ultrasonography revealed a normal uterus in anteverted position, no myometrial lesions or masses. A hyper-echogenic rod-like structure was sited in the cervical canal. (Figure 1)

A diagnosis of displaced or partially extruded copper-T IUCD was made. The device was subsequently removed by traction on the tail with a long artery forceps and patient was placed on haematinics for 2 weeks. The bleeding stopped completely the next day and the patient regained fitness.

Case 2

Mrs. OO is a 35 year old multiparous woman who presented to the out patient clinic of Life Specialist Hospital with heavy bleeding of 2 days duration. She was Para 3 and all 3 deliveries were by caesarean section. Her last confinement was 5 months prior to presentation and she was still breastfeeding her baby. Her menstruation was yet to return. She had a copper T IUCD inserted six weeks postpartum, precisely 3 months prior to presentation.

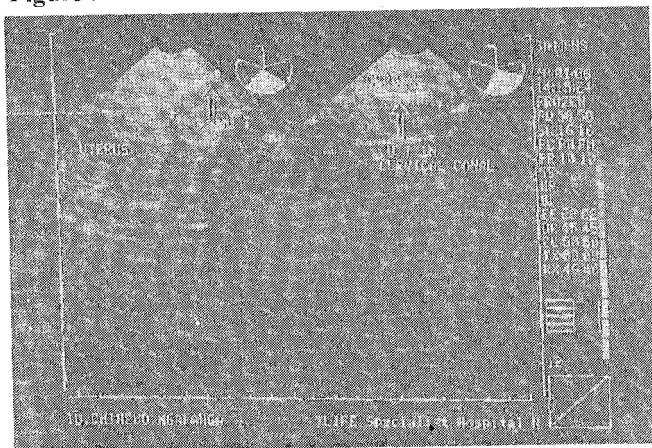
Examination revealed a well-nourished woman who was neither pale nor distressed. Abdominal examination revealed no abnormality. Vaginal speculum

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examination showed a healthy cervix with blood coming from the cervical os. The tail of the IUCD was in-situ and the stem of the copper T was projecting out of the external os.

The IUCD was removed by traction on the tail with a sponge forceps and the bleeding stopped completely a few hours later without any further intervention. A diagnosis of partially extruded IUCD or displaced IUCD was made.

Figure 1: IUCD Located in the Cervical Canal



Discussion

When an IUCD is displaced, it presents with a variety of symptoms including menorrhagia, pregnancy pelvic pain, urinary or gastro-intestinal symptoms depending

on the site of migration^{1,7,9}. When it is completely expelled, bleeding ceases but when it is partly expelled into the cervical canal, the incidence of which is about 15%,¹⁰ it may present with severe menorrhagia as in the two cases discussed here. This could be the effect of local irritation of the cervix, leading to increased production of prostacyclin and failure of the cervix to close because of the presence of a foreign body therein. Hence, the uterus continues to bleed.

It is important that clinicians are aware of this so that the risk of anaemia and other maternal morbidity due to this condition can be taken care of even at the primary health care level. This can easily be done by gentle speculum examination in patients with IUCD presenting with vaginal bleeding. Retrieval can be done using artery forceps, sponge holding forceps or Spencer wells forceps¹¹ in the clinic as in the cases presented.

Ancillary investigations, including ultrasound, which can easily localize a displaced IUCD^{12,13} may not be necessary, especially in resource poor settings. Case 1 had delayed intervention due to the ignorance of the referring health care provider. This informed the use of ultrasound to confirm the diagnosis and exclude any other pelvic pathology.

In conclusion, intra-cervical or partly extruded IUCD is an important cause of severe menorrhagia or vaginal bleeding with associated maternal morbidity. Its management is simple, involving speculum examination and IUCD removal using a range of commonly available instruments and materials. Awareness of this and early intervention is necessary to avert undue maternal morbidity.

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