



PRIMARY PERFORATION OF UTERUS WITH IUCD: CHALLENGES IN DIAGNOSIS AND MANAGEMENT

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ABSTRACT **Introduction:** Intrauterine contraceptive devices (IUCDs) are effective, long-acting reversible contraceptives. Uterine perforation is a rare but serious complication, occurring in approximately 1 per 1,000 insertions, and may result in migration to adjacent organs. **Case Report:** A 22-year-old multiparous woman with a previous lower segment cesarean section presented with vaginal bleeding and vomiting 9 hours after Copper-T insertion. She was hemodynamically stable, but IUCD threads were not visible on speculum examination. Ultrasonography suggested an extrauterine IUCD. Exploratory laparotomy revealed the Copper-T embedded within the omentum with a fundal uterine perforation. The device was removed, omentectomy was performed, and the uterine defect was repaired. The postoperative course was uneventful. **Conclusion:** Primary uterine perforation should be suspected in women with acute symptoms and missing IUCD strings following insertion. Early diagnosis, prompt surgical management, meticulous insertion technique, and regular follow-up are essential to prevent complications and ensure favorable outcomes.

KEYWORDS :

INTRODUCTION

The intrauterine contraceptive device (IUCD), particularly the Copper-T, is one of the most effective, reversible, and cost-effective methods of contraception. Although generally safe, it may be associated with complications such as abnormal uterine bleeding, pelvic pain, expulsion, infection, uterine perforation, and migration into adjacent organs. Uterine perforation is a rare but potentially serious complication, occurring in approximately 1 per 1,000 insertions. Migrated IUCDs may remain asymptomatic for years or present with missing threads, abdominal pain, bleeding, or unintended pregnancy. Prompt diagnosis and surgical removal are essential to prevent further complications.

CASE REPORT

A 22-year-old woman (P1L1) with a previous lower segment caesarean section underwent Copper-T insertion at a peripheral health centre. Nine hours after insertion, she presented with vaginal bleeding and 5-6 episodes of vomiting. She was hemodynamically stable on examination. Speculum examination failed to identify the IUCD threads. Ultrasonography demonstrated the Copper-T in the left lumbar region, suggesting uterine perforation with intraperitoneal migration. Emergency exploratory laparotomy was performed under epidural anaesthesia. The Copper-T was found embedded within the omentum with a fundal uterine perforation. Omentectomy with removal of the IUCD was successfully performed, and the postoperative recovery was uneventful.

DISCUSSION

Uterine perforation may occur during insertion (primary perforation) or later due to gradual erosion (secondary perforation). Risk factors include postpartum insertion, lactation, previous caesarean section, uterine anomalies, and inexperienced insertion. Missing IUCD threads require prompt evaluation with ultrasonography and, if necessary, abdominal radiography or CT scan. Surgical removal is recommended for migrated IUCDs because of the risk of bowel injury, adhesions, abscess formation, and fistula. Laparoscopy is preferred when feasible, although laparotomy may be necessary in complicated cases.

CONCLUSION

Although uncommon, uterine perforation with IUCD migration is a potentially serious complication. Proper insertion technique, adequate training of healthcare providers, careful patient selection, and routine follow-up to confirm thread visibility are essential preventive measures. Early diagnosis and timely surgical management result in excellent clinical outcomes and minimize long-term morbidity.

Learning Points

- Missing IUCD threads should always prompt imaging before assuming expulsion.
- Ultrasonography is the initial investigation; CT may help localize extrauterine devices.
- All migrated IUCDs should be removed because of the risk of

adhesions, bowel or bladder injury, and chronic pain.

- Appropriate insertion technique, post-insertion counselling, and scheduled follow-up reduce the risk of delayed diagnosis.

CLINICAL IMAGES



Img1.jpg : Retrieved Copper-t After Omentectomy



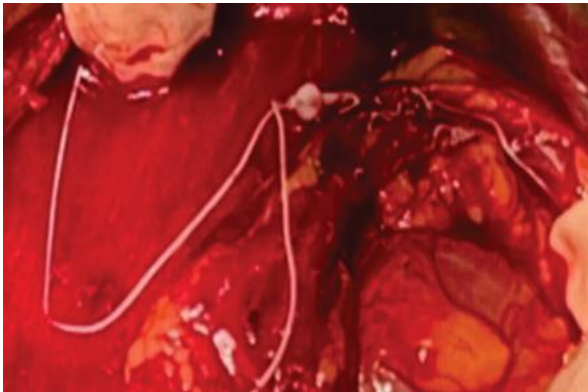
Img2.jpg :figure 2. Intraoperative Photograph Showing Copper-t Embedded Within The Omentum.



Img3.jpg : Intraoperative Image



Img4.jpg: Intraoprative image



Img5.jpg :Intraoprative Image

REFERENCES

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