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Case Report

IUD embedment in the fallopian tube: An unexpected location for a translocated IUD[☆]

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ABSTRACT

Intrauterine devices (IUDs) are the most common form of contraceptive used worldwide. The imaging features of IUDs and their potential complications are crucial to recognize in order to determine adequate positioning and ultimately function of the IUD. Herein, we report a rare case of a copper IUD embedded in the left fallopian tube that required surgical removal. Only a few such cases have been reported in the literature to date.

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1. Introduction

Intrauterine devices (IUDs) are a commonly used form of contraception worldwide and have a 98%–99% effectiveness in prevention of pregnancy [1]. IUDs can be divided into 3 basic types: inert, copper containing, and hormone containing [2]. IUDs prevent pregnancy by producing chronic inflammatory changes of the endometrium and fallopian tubes that have spermicidal effects, inhibit fertilization, and create an inhospitable environment for implantation [1,3,4]. Ultrasonography is the most common initial method of evaluation of IUDs due to its cost-effectiveness, lack of ionizing radiation, and excellent detail of pelvic anatomy [2]. The correct positioning of an IUD within the uterus is that of a T-shape. The stem and the arms of the “T” should be identified, with the proximal end toward the internal os and the distal end in the fundal region within the endometrium [5]. Malpositioning and/or mi-

gration of the IUD from its normal position in the uterine fundus is a frequent complication. Extrauterine migration and embedment in the fallopian tube is an extremely rare complication of IUD placement. Only a few other cases of copper-containing IUD embedment in the fallopian tube have been reported in the literature to date. Herein, we present an additional case, detailing the complications and importance of recognizing translocated IUDs.

2. Case report

A 42-year-old female who was gravida 4, para 3 presented for IUD evaluation. The patient had the copper-containing IUD inserted 1 month prior to presentation and reported no gynecologic symptoms at this time. IUD strings, however, were not identified in physical exam and ultrasound was

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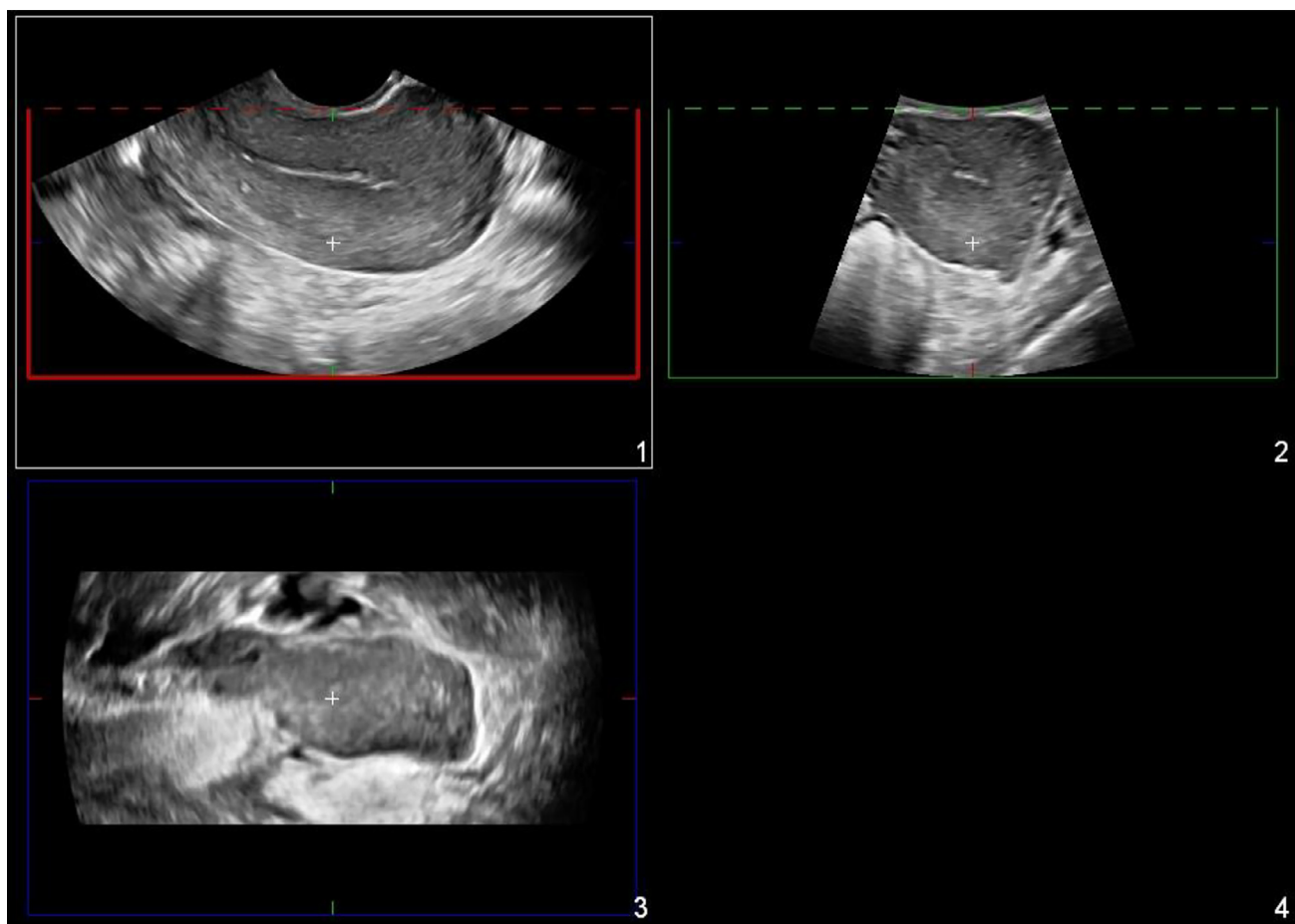


Fig. 1 – Three-dimensional reformatted ultrasound images of uterus without intrauterine device identified. Further evaluation with abdominal radiograph was recommended.

recommended. The gynecologic exam was otherwise unremarkable. Blood chemistries and physical exam findings were within normal limits. Upon transvaginal ultrasound examination, the IUD was not identified, at which time abdominal radiograph was recommended for further evaluation (Fig. 1). Abdominal radiograph demonstrated the IUD projecting in the pelvic region, thereby confirming that it had not been expelled (Fig. 2). Further evaluation with computed tomography showed the IUD in an extrauterine location posterior to the bladder (Fig. 3). The patient underwent laparoscopic removal of the IUD, which was identified partially embedded in the left fallopian tube. The IUD was noted to be in close proximity to the bladder, but did not perforate it. Of note, the patient had a previous IUD device placed 3 months prior, 1 month postpartum, which was also malpositioned and removed. The patient recovered from the surgery well and opted for an alternative method of contraception.

3. Discussion

IUDs are an effective, safe, and widely used form of birth control, accounting for 16.5% use in undeveloped countries and

9.4% use in developed countries [1,6]. The incidence of uterine perforation by IUD is reported to be between 1.3 and 1.6 per 1000 insertions [5]. Uterine perforation is a relatively rare but very serious complication. Perforations of IUD can occur anytime, either immediately by improper insertion or years after insertion secondary to device migration [6]. Serious complications can result secondary to extrauterine migration including perforation and embedment into the adjacent organs. Misplaced IUDs have been presented and described from several organs such as the intestinal tract, including the rectum and appendix, urinary bladder and even buried in the omentum [7–11]. Recognizing the imaging features of misplaced IUDs is crucial in initiating the appropriate workup to locate the device and remove it if necessary.

The risk of IUD perforation is increased with the placement by inexperienced operators, early IUD placement <6 months postpartum, in women with fewer prior pregnancies and in women with an increased number of miscarriages [1]. During the lactation period, endometrial atrophy due to hypoestrogenic state and accelerated involution of the uterus also leads to increased susceptibility to uterine perforation [7,12]. In a study by Andersson and colleagues, at least 80% of their patients with perforated IUD were in the lactation period at the time of insertion [12]. Perforation of

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