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### RESEARCH ARTICLE

#### AN INTRA-UTERINE DISPOSITIF (IUD) MIGRATEUR EN INTRARECTAL : A CASE REPORT

Nabalim I.V, Outright L, Dembélé C, Indami D.B, Eteko T, Ngendabayikwa R, Balde M.A, Benali S and Kouach J.

Gynecology-Obstetrics Service, Mohammed V Military Training Hospital, Rabat, Morocco.

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#### Abstract

The intrauterine device (IUD) is considered one of the most effective and widely used contraceptive methods in the world. The placement of an intra-uterine device is a common gesture in gynecological practice. It is not harmless and the occurrence of a uterine perforation can be serious. Intrauterine perforation is a rare complication, but the most serious. Few publications document the presence of IUD in the intravesicular, sigmoid or causing an appendicular perforation. We report a case of an IUD having migrated in to the rectum. This is a 34-year-old patient, with no previous history, with the notion of placing a copper IUD for 2 years.

The patient consults as part of the annual control of her intrauterine device, the clinical examination being without particularity but the control ultrasound revealed a hyperechogenic image at the level of CDS of Douglas evoking migration of IUDs, confirmed on abdomen image without preparation. Exploratory laparoscopy was indicated, during which only the IUD thread was visible at the peritoneal cavity, the latter being inserted into the rectum between the muscular and mucosa. The patient did not bleed, a 3-month monitoring was initiated, during which the patient spontaneously expelled the IUD during a defecation. An abdomen without preparation allowed us to confirm the expulsion and the absence of complication. We emphasize through this observation and our literature review the importance of strict adherence to recommended measures before placing an IUD, but also the monitoring of the patient. Thus, performing an endovaginal ultrasound to study in particular the anatomy of the uterus before the insertion of the IUD is particularly interesting. Repeated examination immediately after and 4 to 12 weeks after the IUD would allow early detection of complications. Exploratory laparoscopy allows the localization of the IUD in intraperitoneal when the perforation is incomplete, but also its removal in certain situations.

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**Corresponding Author:- Nabalim I.V**

Address:- Gynecology-Obstetrics Service, Mohammed V Military Hospital of Instruction, Rabat, Morocco.

## Introduction

The IUD is a contraceptive commonly used in gynecological practice.

Particularly interesting because of its long life span, and its tolerance, it is presented in several types according to the shape, size, composition, and implantation time.

Copper IUD has a spermicidal effect by making the sperm inactive, while levonorgestrel IUD thickening cervical secretions preventing implantation [1].

The indication of contraception by IUD and the precautions related to the installation of the IUD are governed by strict obligations and rules by the WHO in the context of family planning, allowing to optimize the effectiveness of this means of contraception, but also to limit the complications [2].

## Patient and Observation:-

Ms. A.B, age 34, without any particular medical or surgical history, having as obstetric history a regular cycle, four gestures ,mother of four living children with good psychomotor development, and known to carry a copper IUD for 02 years not controlled since its installation.

She is seeing someone to check her IUD.

The clinical examination finds a patient in good general condition, neurologically stable, hemodynamically and respiratory.

Abdominal and vulvo-perineal examinations are not special.

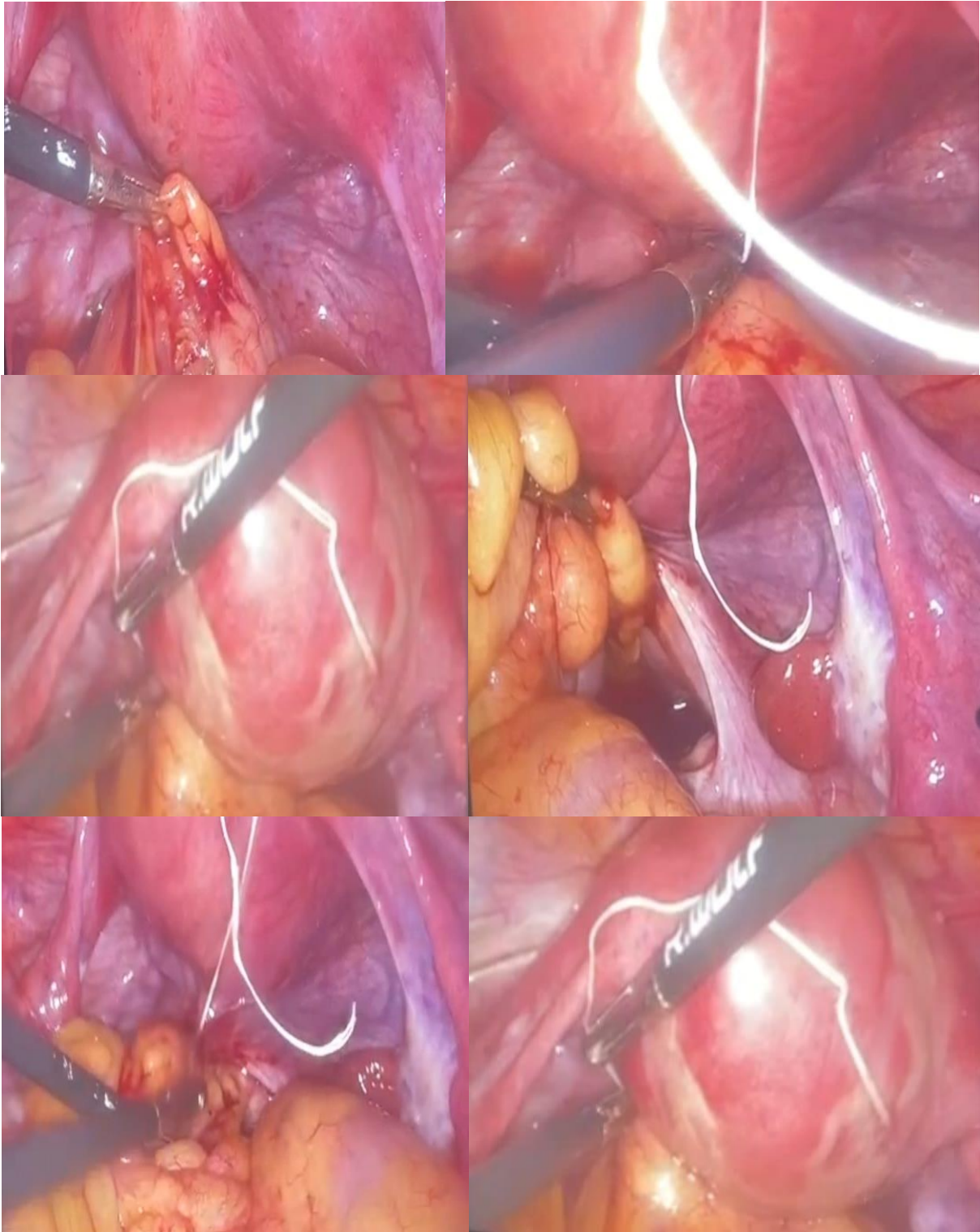
The speculum examination finds a healthy-looking neck, the IUD thread is not visible. Vaginal touch is an objective, normal-sized uterus with no sensitivity or associated stinging.

The endovaginal pelvic ultrasound shows a uterus of normal size, homogeneous echostructure and regular contour, with a line of visible emptiness. The right and left ovaries are normal morphology. A hyperechogenic image at the Douglas cul-de-sac suggests migration of the IUD.

Exploratory laparoscopy was indicated, allowing the presence of the IUD in the intrarectal position between the mucosa and the musculus, with the thread of the latter visible in the peritoneal cavity (Figure 1).

The decision was to carry out a quarterly monitoring after sensitizing the patient to consult for any pelvic or digestive symptoms.

She expels the IUD spontaneously after two months during a defecation, an abdomen without preparation performed the next day confirms the expulsion of the IUD and the absence of acute abdominal complication (Figure 2).



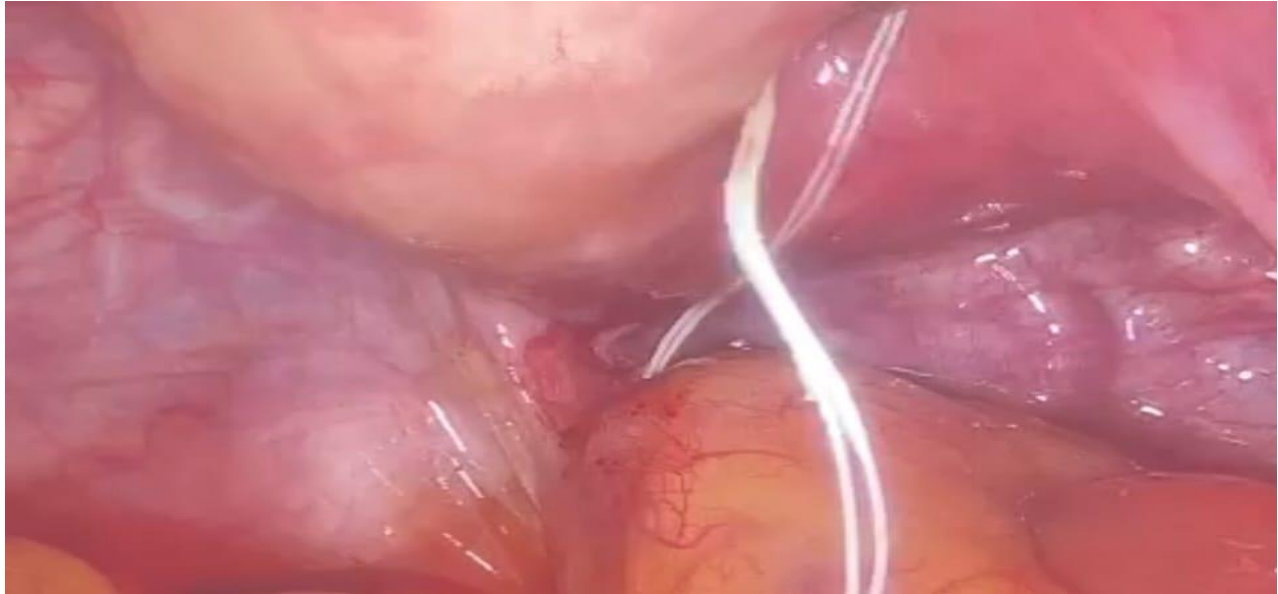


Figure 1:- IUD in peritonealcavity.



Figure 2:- Unprepared abdomen, no IUD.

**Discussion:-**

The intra-uterine device is a very common local contraceptive method. The placement of an IUD, whatever its type, is governed by legal obligations, and knowledge of potential complications is paramount for the attending physician [3].

Regular ultrasound monitoring is equally important, affecting the contraceptive effectiveness on the one hand, but especially the safety of the patient, perforation being a very serious possibility that can condition the morbidity and mortality of the latter.

Uterine perforations following the placement of IUDs or what can also be called the "migratory IUD" are quite rare, in the order of 1.3 per 1000 postings according to some published clinical trials.

This migration may be partial or complete when the IUD completely crosses the uterus and enters the abdominal cavity, thus damaging the nearby viscera [4].

The symptomatology associated with this perforation may be acute and present in the form of significant pelvic aches or acute abdomen, or present in an insidious form after several months or even years by erosion and inflammation of the walls around the IUD. Finally, and most commonly, a migratory IUD can remain asymptomatic and its discovery, as for our patient, is totally fortuitous.

The diagnosis of a migrant IUD is mainly based on endovaginal pelvic ultrasound and its removal can be performed following exploratory laparoscopy, if it has not perforated other vital organs in the mean time.

Finally, as for our patient, it is sometimes better, if the IUD is embedded in the rectum without complications associated, to proceed with a waiting, the patient has a good chance of expelling during a defecation thanks to the expelling efforts [5].

In the event that this expulsion does not occur, or that this situation causes rectorrhages by erosion of the rectal mucosa, a removal by rectoscopy remains possible at any time.

**Conclusion:-**

Although uterine perforation is a rare complication of an intrauterine device (IUD), particular attention should be paid to the placement of the device and ultrasound monitoring.

Unprepared abdomen and exploratory laparoscopy are important for complete perforations, allowing the location of the copper IUD, but also its removal in some cases.

**Reference:-**

1. Recommandation pour la pratique clinique, Contraception, CNGOF 2018. <http://www.cngof.fr>
2. Seleem S., Hills F.A., Salem H.T., El-Nashar E.M., Chard t.: Mechanism of action of the intrauterine contraceptive device: evidence for a specific biochemical deficiency in the endometrium. Hum Reprod 1996; 11: pp.1220-1222.
3. Serfaty D.: Les dispositifs intra-utérin (DIU). Serfaty D. La contraception. 1992. Doin Paris :243-273
4. Kailasuo J, Suhonen S, Gissler M, Lahteenmaki P, Heikinheimo O. Intrauterine contraceptive : incidence and factors associated with uterine perforation-a population-based study. Hum reprod 2012;27(9):2658-63
5. Rowlands s, Oloto E, Horwell D. Intrauterine devices and risk of uterine perforation: current perspectives. Open Access J Contracept 2016,19.