Intravesical lippes loop following insertion for the treatment of Asherman's syndrome: a case report

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Summary
A case report of a 36-year-old Para 6+0 (1 alive) civil servant who developed Asherman's syndrome following repair of ruptured uterus is presented. She had adhesiolysis and insertion of Lippes loop. She defaulted 3 months after presentation and was seen 1 year after with intravesical translocation of the IUCD. This was successfully removed using a forward biting bladder biopsy forceps under direct cystoscopic view.

Keywords: *Intravesical, lippes loop, Asherman's syndrome.*

Résumé
L'e cas d'un functionnaire de 36 ans souffrant du syndrome d'Asherman apres une reparation de rupture de l'uterus est présentét ici. Elle a eu une adhesionolyse et l'insertion de Lippes loop. Elle avait manque le rendez-vous de 3 mois apres traitement et se présenta un an apres avec la translocation intravesicale de DIV. Ceci avait éte énlévé avec succes utilisant les pinces a biopsie de vessie. L'operation etait realise' sous vision cystocopique directe.

Introduction

Missing intrauterine contraceptive device is one of the known complications associated with the use of the device. When the patient cannot feel the string or the string cannot be visualised on speculum examination, it may be due to unrecognised expulsion, uterine perforation or alteration of the intrauterine position such that the strings are withdrawn into the uterine cavity [1].

Although erosion of IUCD into adjacent structure is an exceptionally rare complication, IUCDs have been found in the peritoneum, omentum, appendix, colon and bladder. Intravesical migration is a very rare complication with only about 20 cases reported in the literature [2].

A case of intravesical IUCD (Lippes loop) following insertion for the treatment of Asherman's syndrome is presented.

Case report

Mrs. O. A. is a 36-year-old civil servant. She was para 6+0, 1 live. She had three previous stillbirths and two childhood deaths at about the ages of two years. She presented with a two-year history of amenorrhoea with associated occasional low abdominal pain. About 6 years before cessation of menstruation, she had a ruptured uterus for which she had laparotomy and repair of the uterine rupture. Her menstruation was scanty afterwards until it finally stopped two years before presentation.

Physical examination at presentation did not reveal anything significant. A diagnosis of Asherman's Syndrome was made and this was confirmed by hysterosalpingogram. She had adhesiolysis and insertion of Lippes loop. She was placed on combined oral contraceptive pill after the procedure. She had normal monthly menstruation three times subsequently. She then defaulted.

She then presented again about one year after the insertion of the Lippes loop with amenorrhoea of nine months. The string of the Lippes loop could not be felt on vaginal examination. She then had a pelvic ultrasonography which revealed that the device was in the urinary bladder (Figures 1 and 2).

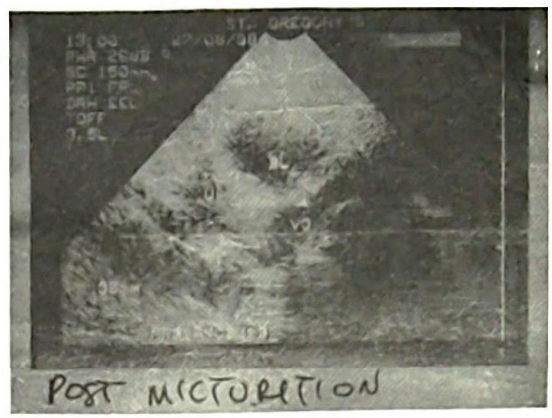

Fig. 1

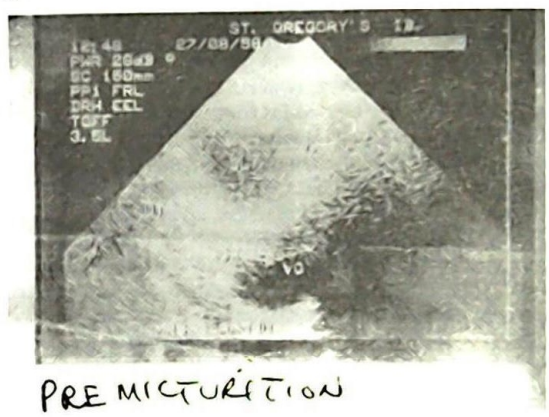

Fig. 2.

This was confirmed at cystoscopy where the loop was found heavily encrusted with calculi. The loop was grasped with a forward-biting bladder biopsy forceps and the cystoscope sheath with the biopsy forceps along with the loop were withdrawn as a unit from the bladder. Residual calculi were washed out from the bladder.

Discussion

Articles on missing IUCG are mainly those resulting from insertion for contraception. An electronic medline search did not yield any paper linking missing IUCD with its use in the management of Asherman's syndrome. This may be due to the relatively short period of time for which the device is used and the fact that the hysteroscope is now used for the management of Asherman's syndrome in many units.

If perforation of the uterus can occur during insertion of IUCD into a normal uterus, it may be reasonable to assume that the risk will be higher when insertion is part of the management of uterine synechiae. This can be explained by the fact that the uterine cavity might have suffered some injury during the event

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or procedure that caused the intrauterine adhesions in the first place and also by the fact that the process of adhesiolysis predisposes to perforation. Most uterine perforations are known to occur at the time of IUD insetion [2].

Although erosion of an IUCD into adjacent structures is an exceptionally rare complication, IUDs have been found in the peritoneum, omentum, appendix and colon. Many studies have shown that the missing IUCD is in utero in the majority of cases [1,3,7]. But Ansari [8] showed that uterine perforation was the commonest cause of missing IUD. The possible sites of missing IUD are intrauterine, peritoneal cavity, myometrium and very rarely, in the bladder. Migration of IUD into the bladder is a very rare complication [2,9]. In fact, Dietrick et. al. [9] reported their own case in 1992 as the 19th ever reported in the literature of migration of IUD into the bladder.

Although perforation of the uterus by an IUCD is often a silent phenomenon, erosion into the bladder usually causes voiding symptoms [9]. The patient typically presents with irritative voiding symptoms, recurrent urinary tract infections, and/or haematuria. There may be a constant dull abdominal pain and menouria [9].

Once an IUD has eroded into the bladder it usually becomes either partially or totally encrusted with calculus [9]. The degree of calculus formation is variable and independent of the duration in the bladder. Bladder calculi are rare in women, therefore, the presence of bladder calculi should raise a suspicion of the presence of a foreign body.

Despite the theoretical higher risk of uterine perforation during adhesiolysis than insertion for contraceptive use of an IUD, reports of uterine perforation is rare in the literature. This may be explained by the fact that while contraception-related IUDs are mostly inserted by non-physicians, insertions for the management of uterine synechiae are handled by physicians. The number of IUDs inserted for contraception, which is much higher than that for other user, may also be a reason for the number of reported cases of perforation in relation to contraceptive usage.

Erosion of an IUD into the bladder should be considered whenever a woman with an unretrieved IUD presents with irritative voiding symptoms, pelvic pain and/or haematuria.

Ultrasonography has been found to be very useful in locating ectopic IUCD in the myometrium or adjacent to bowel loops [2].

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