Case report

CASE REPORT:A RARE CASE OF MISPLACED COPPER - T IN APPENDIX ALONG WITH APPENDICITIS

ABSTRACT

INTRODUCTION: Uterine perforation is one of the serious complications associated with use of intrauterine contraceptive device (IUD). Perforation can occur during insertion or later. Delayed onset of symptoms is mostly due to chronic inflammatory reaction of copper-containing IUD.

CASE REPORT: Presenting a 28 year old with pain over right iliac fossa since 6 months with misplaced copper t which had penetrated into the tip of appendix. Appendectomy was done and copper T was retrieved.

CONCLUSION: The impacted copper t had caused local inflammatory changes leading to appendicitis. Patients with IUD should be alerted about the possibility of its migration. Regular self examination for “missing threads” is useful in the early detection of migration of the IUD.The treatment of a migrated IUD is surgical, either laparoscopy or laparotomy. Withdrawal of the migrated IUD is advisable even if its migration has not given rise to any clinical symptoms.

KEYWORDS: IUCD, Appendicitis, migration, perforation.

UNDER PEER REVIEW

INTRODUCTION

Uterine perforation is one of the serious complications associated with use of intrauterine contraceptive device (IUD). Uterine perforation by IUD can involve several neighbouring organs. This is a rare complications.

Intrauterine contraceptive device (IUD) has been widely used since 1965 [1]. Perforation of the uterus by an IUD is a rare and serious complication, occurring in 1/350 to 1/2 500 insertions [2]. Perforation by IUD can involve

several neighbouring organs such as the bladder, and particularly the intestinal tract resulting frequently in serious complications which require intensive treatment including intestinal surgery. Perforation can occur during insertion or later. Perforation occurring at the time of insertion correlates directly with the skill of the clinician. Delayed onset of symptoms is mostly due to chronic inflammatory reaction of copper-containing IUD.

CASE REPORT - A young 28 year old female presented with the complaint of pain over the right iliac fossa since 6 months.
No additional symptoms

LMP-31/05/2022
Past menstrual history: Normal cycle, which was regular(every 28-30days), with moderate flow lasting for 3-5 days not associated with pain.

Obstetrical history -P2L2 both FTND with 8 years of married life.
No other significant past, personal and family history
Patient conscious ,cooperative and well oriented to time, place and person
Patient was afebrile, pulse -80 bpm , BP 120/70 mm hg, pallor present.
systemic examination RS ,CVS , CNS- NAD
Per abdomen - soft
-Tenderness + over right iliac fossa
Per vaginum - uterus retroverted, retroflexed, normal sized uterus, bilateral fornices free and non tender.

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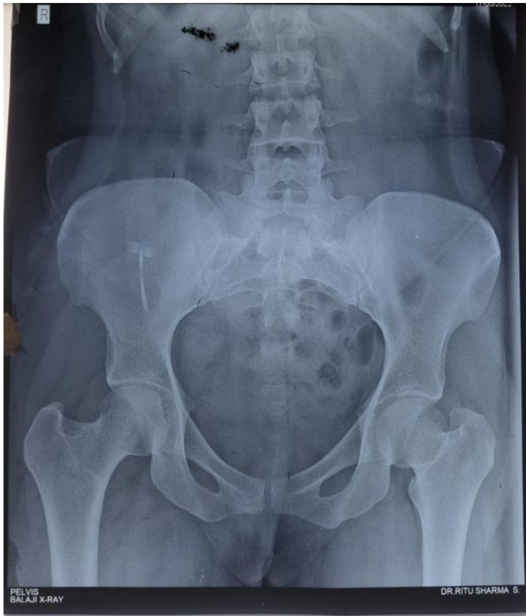
INVESTIGATIONS:

Cbc- Hb– 9.9 gm%,
Tlc – 5900 cell/cumm,
Dlc- 66/25/4/5
platelet – 2.23 lac/cumm
RBS – 111mg%
RFT –S.Creat –0.5 mg%
LFT – SGPT – 16 IU/L,
SGOT – 23 IU/L,
S.billirubin – 0.6 mg/dl
Blood group – O positive
Chest X Ray and ECG are within normal limits.

Ultrasonography: –

Linear echogenic strand like foreign body object is noted in the right iliac fossa which is causing local inflammatory changes in the form of surrounding fat stranding. The foreign body is within close proximity to appendix, maximum diameter measures 2.5mm. Further evaluation with clinical correlation is recommended.

Figure 1 : X Ray Abdomen Erect posture



Histopathology report

The section shows focal ulcerated mucosa with few hyperplastic lymphoid follicles in the mucosa. Few scattered neutrophils are seen in the submucosa. Blood vessels are congested. Foreign body granulomas are not seen. Malignancy is not seen.

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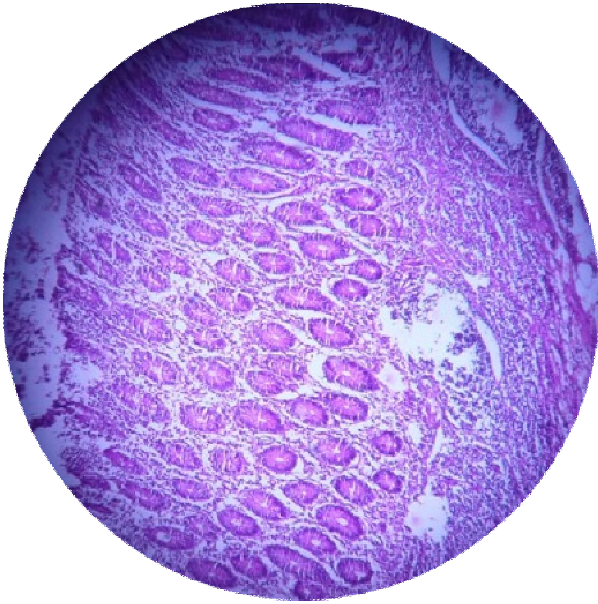

Figure 2: Ulcerated mucosa with few hyperplastic lymphoid follicles in the mucosa

SURGERY:

Exploratory laparotomy + appendectomy

Intra operative findings :

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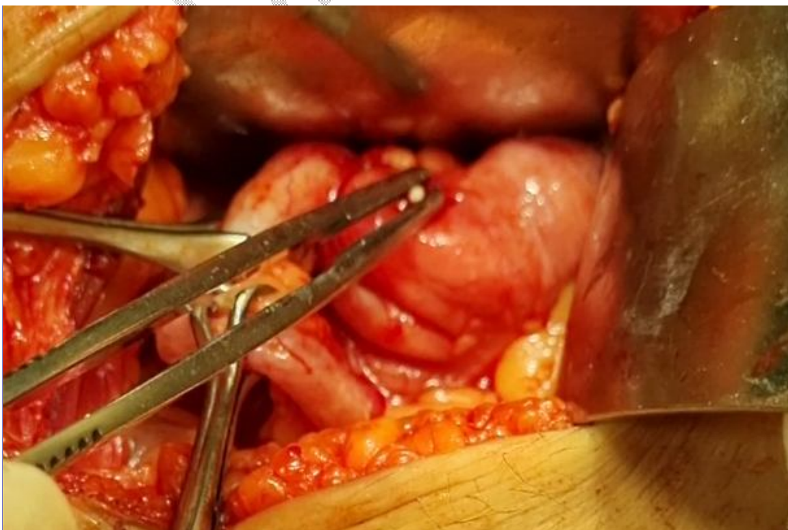

Figure 3 Exploratory laparotomy

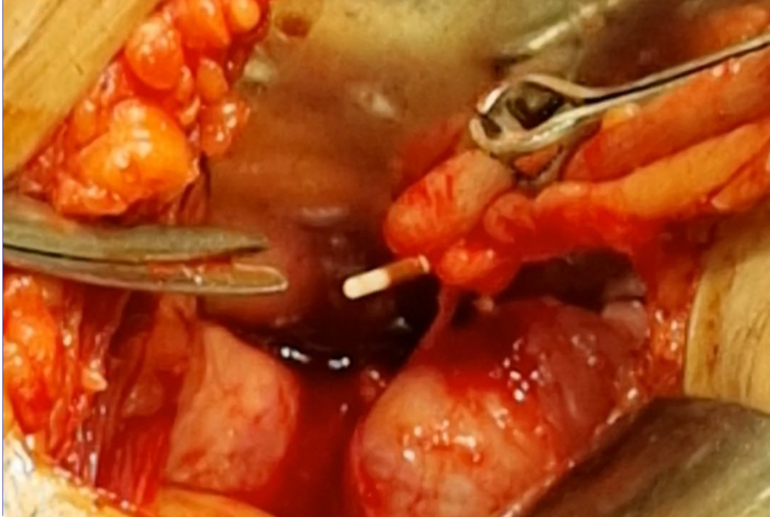

Figure 4 appendectomy

Uterus and both adnexa normal. However by palpatory method over appendix, the vertical lines of IUCD could be felt.

The IUCD was located in the abdominal cavity behind the ileocecal junction and its tip had penetrated the tip of appendix. The whole area was edematous and covered with omentum. No fecalith impaction in appendix was found. Appendectomy was performed and the IUD was retrieved. The patient recovered uneventfully.

Haemorrhagic fluid is present at the tip of the appendix.

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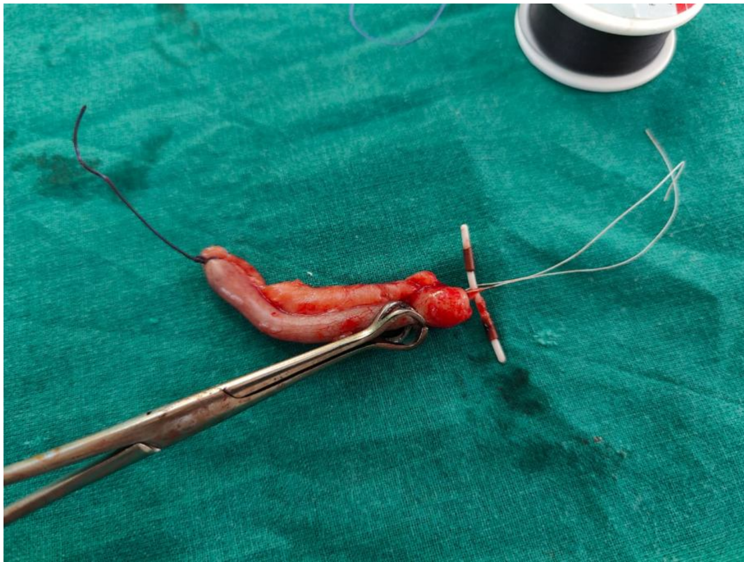

Figure 5 : Haemorrhagic fluid is present at the tip of the appendix.

Post-operative care

After exploratory laparotomy with appendectomy i/c/o misplaced CuT.

TPR BP I/P O/P, AG,BPV was monitored.
Patient was given hydration, antibiotic and analgesic cover.
The patient was discharged on day 4 of surgery.

DISCUSSION AND CONCLUSION:

The impacted copper t has caused local inflammatory changes leading to appendicitis.

IUD is generally a safe modality for long-term contraception. Associated complications are bleeding, infection, ectopic pregnancy and uterine perforation. Uterine perforation is one of the most serious but uncommon complications associated with an IUD. The mechanism of perforation is thought to be the insertion procedure or chronic inflammatory reaction with gradual erosion through the uterine wall [1]. The incidence is influenced by several factors including the timing of insertion, parity, previous abortions, type of IUD inserted, experience of the operator and position of the uterus.Most of the perforations take place at the time of insertion. Delayed onset of symptoms supports secondary migration [1].

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Patients with IUD should be alerted about the possibility of its migration. Regular self examination for “missing threads” is useful in the early detection of migration of the IUD. A plain radiograph of the abdomen is usually the initial examination of choice to verify the presence of the IUD in the pelvis. Once found, an ultrasound examination has to be done to determine the location of the IUD relative to the uterus. The treatment of a migrated IUD is surgical, either laparoscopy or laparotomy. Withdrawal of the migrated IUD is advisable even if its migration has not given rise to any clinical symptoms and can avoid further complications like bowel perforation, bladder perforation, or fistula formation [3].

REFERENCES:

1. Zakin D, Stern WZ, Rosenblatt R. Complete and partial uterine perforation and embedding following insertion of intrauterine devices. I. Classification, complications, mechanism, incidence, and missing string. Obstet Gynecol Surv. 1981;36:335–353.

2. Ohana E, Sheiner E, Leron E, Mazor M. Appendix perforation by an intrauterine contraceptive device. Eur J Obstet Gynecol Reprod Biol. 2000;88:129–131.

3. Berman MC, Cohen HL. Diagnostic Medical Sonography. Lippincott; 1997. Obstetrics and gynaecology: A guide to clinical practice; pp. 569–571

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