

Forgotten intrauterine device contributing to infertility

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Abstract

The aim of the study is to show that long standing forgotten intrauterine device contributes to infertility, reporting three cases presented at Central Hospital Warri, Nigeria, a government tertiary health center. Three cases of forgotten intrauterine contraceptive device (IUCD) contributing to infertility were seen. Two were inserted for contraceptive reasons while one was inserted while being managed for uterine synechae. Health care providers should ensure proper documentation of all procedures carried out, adequate counseling which should include taking an informed consent and also ensuring both short and long term follow up of their clients. Also all patients being evaluated for infertility and clients with past history of intrauterine device must have a speculum examination and ultrasound scan carried out.

Introduction

Intrauterine devices (IUD'S) are long-term contraceptive devices commonly used in prevention of pregnancy. It is also used as an emergency contraceptive and in the treatment of Ashermans syndrome in setting such as ours where hysteroscopic adhesiolysis is not commonly done. Studies in two regions in Nigeria shows that it is the most commonly used method of female contraception.^{1,2} Intrauterine devices insitu can cause complications such as irregular vaginal bleeding, pelvic infections, perforation of uterus and tanslocation.^{2,3-7} They can give rise to infertility by way of pelvic infections. Popular intrauterine devices in Nigeria are the copper T 380A and the lippes loop. While copper T380A is supposed to last for eight to ten years when used as a contraceptive device, the Lippes loop was commonly used in the past to treat Ashermans syndrome in combination with estrogens and progesterone and it is left in utero for 3 months. Long standing forgotten intrauterine device has been associated with actinomycosis endometritis.⁵

I present 3 cases of forgotten IUD'S con-

tributing to infertility seen in a private gynaecological practice.

Case Reports

Case #1

Mrs. OO is a 34-year-old Para 2 (2 alive) staff nurse who presented in our gynecological clinic with a 6-year history of infertility. Her last childbirth was 7 years prior to presentation. Both deliveries were by spontaneous vertex delivery. She had 2 previous history of primary postpartum hemorrhage necessitating blood transfusions in both instances. At the last delivery evacuation of retained products of conception was done after manual removal of the placenta. The managing gynecologist then decided to insert an intrauterine contraceptive device (copper T380A). She said she was under anesthesia and was never told that such a device was insitu. Intrauterine device was discovered on routine speculum examination and was further confirmed by ultrasound scan. A copper T 380A was later removed. There were no other complications. She had hysterosalpingogram, which was essentially normal; conception was subsequently achieved and was delivered of a female neonate by spontaneous vertex delivery with good outcome.

Case #2

Mrs. QB is a 37-year-old Para 0 secretary who presented in our gynecology clinic with an 8 year history of infertility. She had been evaluated previously in an infertility clinic and both hormonal profiles and seminal fluid parameters were normal. Four years prior to presentation, she had been managed for uterine synechae and a lippes loop was inserted. She had had four premarital terminations of pregnancy with the last one complicated by lower abdominal pains and offensive vaginal discharge. When she presented in our clinic, routine speculum examination again revealed the thread of the intrauterine device. She admitted that she was managed for hypo menorrhoea/amenorrhoea but was not told that a device was inserted in her uterus and would have been removed at about 3 months post insertion. Again ultrasound scan confirmed it. A lippes loop was later removed. Hysterosalpingogram revealed multiple filling defects with bilateral tubal block. There were no other complications but she defaulted and did not present for follow up after being counseled for hysteroscopic adhesiolysis and possible *in vitro* fertilization. This may have been due to the financial implications involved.

Case #3

Mrs. EE is a 38-year-old para 0⁺ petty trader

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Key words: forgotten intrauterine device, infertility, counseling, speculum examination, ultrasound.

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who has been married for 8 years with no child. She had 2 premarital terminations of pregnancy. At the age of 18, the mother took her to a nurse who inserted an intrauterine device for fear of unwanted pregnancy. Patient never knew that she was to go for regular follow up. She had visited several doctors both orthodox and traditional in other to get pregnant. Routine speculum examination revealed an intrauterine device, which was confirmed by ultrasound scan. A copper T 380A was subsequently removed. She did not have other complications. Hysterosalpingogram done was essentially normal. She was delivered of a female child by spontaneous vertex delivery with good outcome.

Discussion

The three cases mentioned above are not uncommon occurrences in tropical practice with profuse documentation in the literature. There are lots of lessons to learn from these cases. These patients would have visited several health care givers but did not have the benefit of a speculum examination, which would have picked up the threads of the intrauterine devices. It also shows that the quality and level of counseling these patients got was very poor. It is most likely that they were not counseled at all as all the patients are literate. Some practitioners may not even counsel their patients because of the erroneous impression that they might not understand issues at stake. In the first case presented, even after the anesthesia, details of the procedure were not told her. It is also possible that they were told but they forgot, though they denied this fact.

All 3 patients presented in their thirties with the last two in their late thirties. A lot of fertile years were wasted and we do know that the peak of reproductive potential for women is between 24 to 28 years.

All patients did not have any overt complication apart from infertility. There was no haemorrhage or infection. Actinomyces Israeli infection has been associated with long-standing intrauterine device,⁵ but this was absent in the cases. The idea of compelling adolescents to use a particular method as was in case 3 amount to infringing on their reproductive health rights. Toma and Jamieson proposed that following pre-insertion screening for sexually transmitted infections related cervicitis and with consistent follow-up following insertion, intrauterine devices are well-tolerated by properly selected and counseled adolescents who require an easy and effective long-term method of birth control.⁶ Marcus described 2 women with the forgotten coil who had return of fertility and improvement of gynaecological symptoms after removal.⁷

Case 3 was not properly selected neither was she screened or followed up.

The place of ultrasound scan in confirming

the diagnoses is invaluable⁸ though all cases were diagnosed at pelvic examination and confirmed at ultrasound. Good history taking and routine ultrasound for past users of intrauterine devices is imperative before undertaking invasive procedures such as hysterosalpingogram and laparoscopy.⁹

In conclusion, health care providers should ensure proper documentation of all procedures carried out, adequate counseling, which should include taking an informed consent and also ensure both short and long term follow up of their clients. Also all patients being evaluated for infertility and clients with past history of intrauterine device must have a speculum examination and ultrasound scan carried out.

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