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CASE REPORT

A Rare Case of Bicornuate Uterus with Embedded Intrauterine Contraceptive Device

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ABSTRACT

Early intrauterine contraceptive devices (IUCDs) like Lippes Loop were intended for long-term use until menopause and hence often retained for years, and many patients present well into menopause still bearing a Lippes Loop either deliberately or forgotten. We present a case of a 65-year-old postmenopausal female patient presented with complaints of spotting per vagina since 20 days, associated with white discharge per vagina. Ultrasound abdomen showed calcified endometrium with IUCD in the cervical canal. Hysteroscopy was done. As IUCD could be visualized but could not be removed, hence hysterectomy was done.

Keywords: Bicornuate uterus, Lippes loop, Menopause

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CASE REPORT

A 65-year-old postmenopausal female patient, P6L4, presented with complaints of spotting per vagina (PV) since 20 days, associated with white discharge per vagina (WDPV) which was foul smelling, pain abdomen, and history of intrauterine contraceptive device (IUCD) inserted 35 years back. No history of removal of IUCD.

On per speculum there was WDPV, foul smelling in nature, cervix flushed with vagina, and Copper T thread was not visualized. On bimanual examination of the uterus, it was found to be atrophic, with forniceal tenderness.

The complete blood picture and blood sugar levels were found to be normal. Pap smear report was inconclusive. Ultrasonography of the abdomen showed calcified endometrium with IUCD in the cervical canal. A provisional diagnosis of IUCD *in situ* for evaluation was made.

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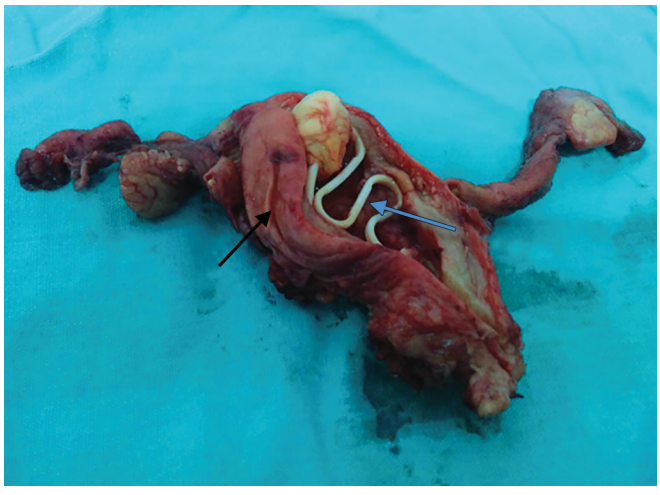

Fig. 1: Gross specimen of uterus with bicornuate uterus. Right horn (black arrow), left horn with Lippes loop (Blue arrow)

The patient was scheduled for examination under anesthesia with dilation and curettage (D&C). The per speculum examination revealed stenosed cervix, and on dilating the cervix foul smelling discharge through os was present (pyometra). The PV examination revealed atrophic uterus, and fornices were found to be free. Dilation and curettage showed chronic nonspecific cervicitis. Hysteroscopy was done. Intrauterine contraceptive device could be visualized but could not be removed; hence hysterectomy was done.

On macroscopic examination, both the tubes and ovaries were normal. Uterus was atrophic and bicornuate with left rudimentary horn (Fig. 1). The patient was discharged on 8th postoperative day, with no complications and was advised to come for regular follow-up.

DISCUSSION

Since the 19th century IUCDs have been in use. Dr. Jack Lippes made the first model of his "Double-S" IUCD – Lippes Loop, which is a flexible polyethylene plastic loop of suitable size for the uterine cavity.[1] It subsequently went on to become the standard for other IUDs to be compared with.[2] At present, it is no longer in use.

This IUCD was commonly used from the 1960s to the 1980s.[3] Prolonged use of this device was common. The time period varied from 22 to 44 years. Those women who used this device, most commonly, presented with

complaints of uterine bleeding during postmenopausal period and inflammatory pelvic disease.[3] The cause of the bleeding can be due to the migration of the device into the uterine wall and also a chronic inflammation of the endometrium.[4] However, women with IUD, who present with bleeding after menopause should be thoroughly examined, as it can lead to a significant endometrial pathology. The measurement of the endometrial thickness by ultrasonography may be unreliable in the presence of an IUCD.[3] Hence, investigation should include hysteroscopy.

The incidence of difficulties associated with IUCD removals is rarely defined, but may occur in up to 9% of follow-up visits of women who have IUD. Intrauterine devices which are migrated within the uterine cavity may require operative removal in 40% of cases even in the hands of skilled operators. These migrated IUDs should be removed, as they are less likely to be correctly sited at the fundus and thus increase the risk of pregnancy.[5]

The Faculty of Sexual & Reproductive Health Care (FSRH) guidance on contraception for women aged over 40 years states that after the menopause intrauterine methods of contraception should be removed rather than left *in situ* as cases of pyometra and actinomycosis have been reported in postmenopausal women with IUCD.[6]

At present, IUDs are frequently used for reversible family planning method, globally. The earlier IUD was made of plastic materials. It has been replaced by new devices, which release copper or levonorgestrel. These changes have increased the efficiency of IUDs.[7,8]

CONCLUSION

A long-standing IUCD can lead to many problems starting from infertility to postmenopausal bleeding, pain abdomen, fever, malaise due to pelvic inflammatory disease, and actinomycosis. Timely removal of IUD is highly warranted to avoid the above complications.

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