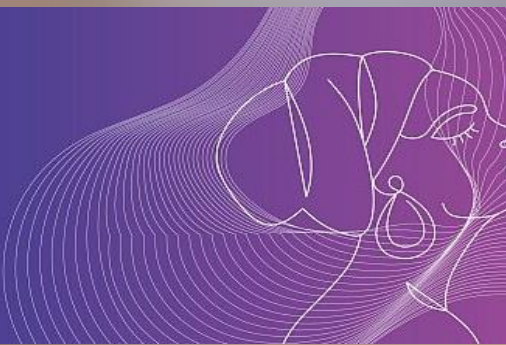


Silent Migration: Case Insights into IUCD-Related Uterine and Bowel Injury

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Objectives

The objective of this report is to emphasize:

- The importance of adhering to safe IUCD insertion techniques,
- Early recognition and diagnosis of IUCD complications,
- The role of multidisciplinary management
- Evidence-based prevention and follow-up strategies.

These case reports illustrate how prompt imaging, surgical planning, and interdisciplinary collaboration can prevent severe outcomes like bowel injury or sepsis.

Discussion

Uterine perforation occurs in 0.1–0.3% of IUCD insertions.

Risk higher in postpartum (<36 weeks), breastfeeding, uterine anomalies, retroverted uterus, surgical history (e.g., LLETZ), and insertions by less experienced providers.

Complications: Can lead to adhesions, chronic pain, infertility, or organ injury. 15% of perforations involve bowel or bladder. Bowel involved in 3–7.5% of cases.

Imaging: Ultrasound first-line; X-ray or MRI for migrated

Management

Partial perforations:

--hysteroscopic or ultrasound-guided removal.

Complete perforations:

--laparoscopy with pre-op bowel preparation.

Prevention

Delay insertion until ≥ 12 weeks postpartum.

Ultrasound guidance in high-risk cases.

Ensure proper training and post-insertion follow-up with

Contact Information

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Case 1

Patient

51-year-old, History of endometriosis; previous LLETZ for CIN 3, Copper IUCD (Cu-IUCD) inserted in hospital after failed GP attempt (under local anaesthesia)

Symptoms

Severe, acute lower-abdominal pain 2 weeks post-insertion.

Examination Findings

Pelvic tenderness; IUCD threads not visible on speculum

Imaging

- Pelvic ultrasound: IUCD absent from uterine cavity
- CT/MRI: device located in pelvis, adherent to uterosacral ligament and in close apposition to sigmoid colon with dense adhesions

Management

a. Multidisciplinary Team : Gynaecologist (lead surgeon), Colorectal surgeon

b. Treatment

- Planned diagnostic laparoscopy with pre-op bowel prep.
- Adhesiolysis done; IUCD embedded between uterine serosa and sigmoid colon, no bowel perforation
- Laparoscopic retrieval of IUCD; bowel intact - no resection



Case 2

Patient

26-year-old woman, Six months postpartum

Underwent Cu-IUCD insertion by general practitioner

Symptoms

--Immediate discomfort during insertion

--Later presented with abdominal pain and signs of sepsis

Examination Findings

--Suspected uterine perforation at time of insertion

--IUCD threads visualized embedded in anterior uterine wall during hysteroscopy

--Failed retrieval attempt during hysteroscopy

--IUCD threads visualized embedded in anterior uterine wall during hysteroscopy

Imaging

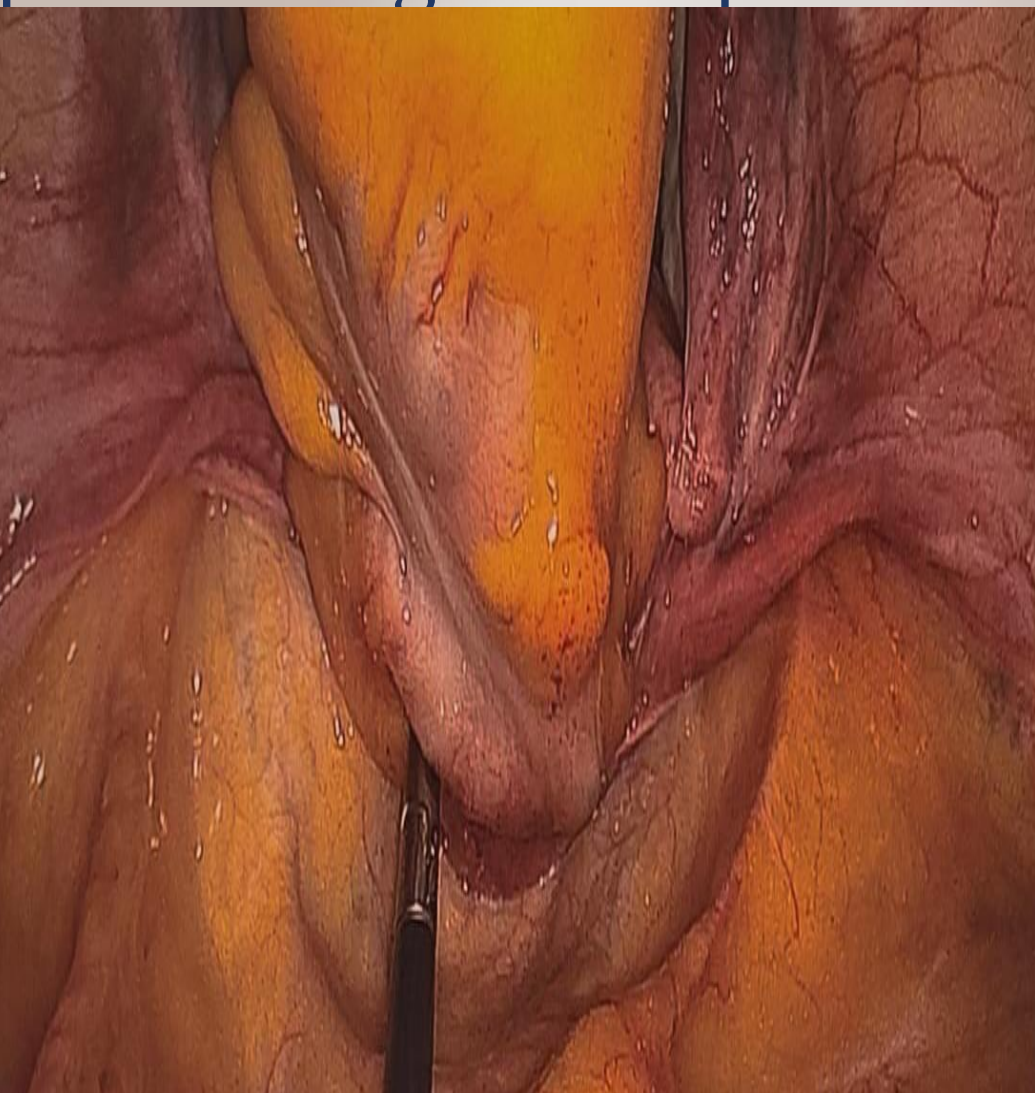
- MRI confirmed full-thickness uterine perforation
- IUCD located adjacent to the sigmoid colon

Management

a. Multidisciplinary Team: Gynaecologist, Colorectal surgeon

b. Treatment

- Emergency diagnostic laparoscopy due to sepsis
- IUCD partially embedded in anterior myometrium and in contact with sigmoid serosa, no bowel perforation.
- Adhesiolysis and laparoscopic retrieval of IUCD



Conclusions

These cases highlight importance of prevention, early detection, and multidisciplinary management in IUCD related uterine perforation, helping avoid major complications

like bowel resection.

Key recommendations:

- Standardize IUCD insertion training
- Ensure follow-up in high-risk cases
- Use imaging when complications are

suspected

Future focus:

- Post-insertion ultrasound utility
- Safer IUCD designs