MIGRATION OF INTRAUTERINE CONTRACEPTIVE DEVICE AS CAUSE OF BLADDER STONE

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ABSTRACT

A 34-year-old multiparous woman who had a Copper T intrauterine contraceptive device (IUCD) inserted eight years ago presented with irritative voiding symptoms. Migration of the IUCD from the uterine cavity to the bladder with formation of a calculus was diagnosed. The calcified intrauterine contraceptive device was removed with laparotomy.

Key words: bladder; foreign body; calculous; intrauterine contraceptive device

INTRODUCTION

Intrauterine contraceptive devices (IUCD) have been used as an effective, safe, and economic contraceptive method for many years (1). Although the action mechanism of the IUCD is controversial, many recent reports have suggested that the IUCD prevent implantation of the fertilized ovum or cause spermicidal activity in the intrauterine cavity (2).

Since the introduction of the IUCD, many complications such as dysmenorrhea, hypermenorrhea, pelvic infection, pregnancy, septic abortion, uterine perforation and migration into adjacent organs have been reported (3,4).

CASE REPORT

A 35-year-old female patient presented with a 3-year history of irritative voiding symptoms. The patient had a Copper T-shaped IUCD inserted eight years ago. As the IUCD had been assumed to have fallen down in gynecologic examination, an oral contraceptive medication had been counseled 6 years ago.

Physical examination revealed suprapubic sensitivity. In pelvic examination, she had normal vulva and vagina, multiparous column, and normal sized, firm but tender uterus in anteversion. The IUCD’s string was not observed. Urinalysis showed pus cells and microhematuria while urine culture was sterile. Plain film of the abdomen showed a 1-cm calcified mass at the tail of IUCD in the pelvis (Figure-1). Pelvic

Figure 1 - Plain film of the abdomen demonstrating a 1-cm calcified mass at the tail tip of an intrauterine contraceptive device.
ultrasonography revealed the IUCD, whose tip was calcified, extending from the myometrium of the uterine corpus to the lumen of the bladder. Cystoscopy demonstrated a fixed stone formation of 1 cm in size surrounded by mucosal erythema and edema at the posterior bladder wall, while hysteroscopy revealed no abnormalities. The calcified IUCD (Figure 2) was removed with laparotomy and the patient was discharged from hospital seven days after operation with no complications.

CONCLUSION

Migrations of IUCDs into the peritoneum, omentum, appendix, colon, wall of iliac vein and bladder have been reported up to now. The migration of an IUCD into the bladder is extremely rare. Indeed, to our knowledge, there are only 30 previous cases in the literature. In these cases, beginning of the symptoms ranged from 3 months to 5 years and determining the migration of the IUCD ranged from 6 months to 16 years (3,4). In our case, the migrated IUCD caused symptoms after 5 years and was removed eight years after insertion.

As primary stone in the bladder is an uncommon pathology in females, a foreign body must be also thought of in hematuria and suprapubic pain should alert physicians to a foreign body when diagnosing bladder stones in females. Moreover, the patients with IUCD should also be alerted to the possibility of the contraceptive device migration.

REFERENCES


Figure 2 - Calcified intrauterine contraceptive device removed from the bladder.

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