CASE REPORTS

Uterine perforation by GyneFix frameless IUD: Two case reports

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Abstract

Two cases of uterine perforation are described, occurring 11 days and 4 months, respectively, after the insertion of GyneFix, a frameless intra-uterine contraceptive device (IUD). In both the cases initial ultrasound scan showed the intra-uterine position of the device. Removal of the IUD, either by laparoscopy or laparotomy, had to be carried out. Awareness of this complication, insertion of GyneFix by a trained operator, appropriateness of ultrasound scan monitoring and possible underreporting of this complication are discussed.

Key message points

- Perforation of the uterus can occur with the frameless IUD GyneFix.
- Skillful insertion by a trained operator is essential.
- Use of ultrasound scanning in problem cases requires close collaboration with ultrasonographers.
- Reporting all perforations by GyneFix and evidence-based information is advocated.

Case 1

A 28-year-old nulliparous lady requested the insertion of an IUD, and a community family planning consultant subsequently inserted a GyneFix. A normal pelvic examination was noted and the GyneFix insertion was uneventful. At the time of the clinic attendance, she had been amenorrhoeic for 2.5 years on the progestogen-only pill, and was in a stable relationship. Eighteen months prior to this consultation she was seen in gynaecological clinic because of dyspareunia, and was suspected to have chronic pelvic inflammatory disease. Her Chlamydia culture was positive, with a co-existent Gardnerella infection for which she received doxycycline and Flagyl. At the time of GyneFix insertion she was entirely asymptomatic, hence further Chlamydia tests were not performed.

Two days after insertion of GyneFix, she presented to her general practitioner (GP) complaining of chest pain and lower abdominal pain. She was seen at the local hospital in the gynaecology department where a clinical examination was unremarkable. An ultrasound scan examination showed an IUD in situ. She was reassured. However, in view of her prolonged amenorrhoea, a serum ß-HCG was performed and was found to be less than 2 units per litre (normal range 0 - 10 u/l). It was planned that she should be reviewed in 4 weeks’ time in the gynaecological clinic.

One week following insertion of GyneFix she re-attended the family planning clinic with crampy lower abdominal pain and requested removal of the GyneFix IUD. Clinical examination failed to locate the thread of the device, but transvaginal scan showed the IUD in situ. An attempt was made to remove the IUD under general anaesthetic, after dilatation of the cervix and using polyp removal forceps. However no device was felt in the cavity. On uterine sounding a small perforation was inadvertently made in the posterior uterine wall near the fundus. She was observed on the gynaecological ward and was commenced on prophylactic antibiotics in view of perforation of the uterus.

In the next 48 hours her abdominal pain continued and she had ultrasound scan and an X-ray of her abdomen. The ultrasound scanning failed to show the IUD in the uterus, and X-ray revealed it to be in the pelvis.

The patient underwent laparoscopic removal of the IUD 11 days after insertion. Laparoscopy was performed using the standard technique and carbon dioxide for insufflation. A normal sized uterus, tubes and ovaries with no signs of infection were noted. Approximately 20 mls of blood-stained fluid in the pouch of Douglas was noted, with a 5–7 mm sized uterine perforation on the right side of the fundus. There was no bleeding from this site and the perforation appeared to be a week old.

The abdominal cavity was explored with the laparoscope and the GyneFix IUD was found in the layers of the small intestine. The knot end of the GyneFix was embedded in the layers of the small bowel, but was able to be detached with a gentle pull usingatraumatic-grasping forceps. It was removed laparoscopically. The patient was allowed home 24 hours post-operatively as her symptoms had settled.

She was reviewed in the gynaecological clinic 4 weeks after laparoscopic removal of the IUD. She complained of lower abdominal pain. Clinical examination as well as transvaginal scanning of pelvic organs was unremarkable. She was reassured and was reviewed 4 weeks later. Her abdominal pain settled and she was discharged to her GP.

Case 2

A 34-year-old single nursery teacher attended the community family planning clinic requesting IUD insertion. She had undergone a surgical termination of pregnancy 18 years previously, and had had no other pregnancies.

A consultant in the family planning services fitted a GyneFix IUD in late March 1999. The procedure was performed by the standard technique and was uneventful. She re-visited the clinic after 1 week, when the thread was not visible. However, an ultrasound scan confirmed the IUD in the uterus.

Approximately 3 months after having the IUD fitted, she contacted her GP because of a heavy vaginal bleed with...
clots, and feeling weak and tired. Her bleeding settled on a course of tranexamic acid. However, clinical examination 2 weeks later showed a bulky uterus and a pregnancy test was positive. She was referred to the local hospital for further assessment.

Approximately 14 weeks after the IUD insertion when she attended the hospital, she reported that her last period was delayed by 2 days. Although her general condition was satisfactory, her haemoglobin was 6.9 g/dl. An ultrasound scan examination showed a 22 mm irregular gestation sac equivalent to 7 weeks 6 days by gestation age. A foetal echo was seen, but there was no foetal heart activity. The gestation sac was cloudy. The IUD was not seen in the uterus. X-ray examination showed the IUD present in the lower abdomen. A clinical diagnosis of missed abortion with lost IUD in the abdomen was established.

The patient received 4 units of blood transfusion and underwent suction evacuation of the uterus, laparoscopy and laparotomy. Laparoscopic examination showed the IUD thread to be buried in the omentum. A gentle tug during the laparoscopic procedure could not retrieve the IUD. She underwent a laparotomy where the lost GyneFix IUD was recovered, buried in inflammatory omentum, which was also dissected and sent for histological examination. This confirmed intense acute and chronic inflammation amounting to chronic abscess formation with associated necrosis in the omental tissue. Material from evacuation of the uterus confirmed unremarkable first trimester chorionic villi.

The patient made an uneventful recovery and was reviewed 6 weeks post-operatively in the gynaecology clinic, when she was discharged.

**Discussion:**

Perforation of the uterus is one of the most serious complications associated with insertion of an IUD. The frequency has been estimated between 0.05 and 13 per 1000 insertions, varying according to a number of factors including the device used and the operator’s experience, design of the device or thinness of myometrium; otherwise misleading scan results might result in inappropriate management. It has been recommended to remove the GyneFix if the distance between the peritoneal surface of the uterus and the first copper sleeve is less than 9 mm or greater than 20 mm. Finally, all known cases of IUD perforations, at insertion and delayed, should be reported to the Medical Devices Agency. This is particularly important in the case of GyneFix, given its frameless design and intra-myometrial anchoring device. GyneFix is a highly effective, well-tolerated intra-uterine device for nulliparous and multiparous women. It would be reassuring to have robust evidence-based information that perforations, both immediate and delayed, are no more common than with other IUDs.

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**References**


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