CHAPTER VI

SUMMARY

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During the last few years the Lippes loop has gained world wide popularity and acceptance as an intrauterine contraceptive device. Some of the unsolved problems with regard to the loop which have engaged the attention of workers include its mode of action, the causes of side effects, the way in which the loop is sometimes expelled and perforation of the uterus.

Although the effectiveness and safety of the IUD have been recently the subject of many discussions, yet only few authors have reported uterine perforations.

The loop has a perforation rate ranging between 0.1 and 8.7 per 1000 insertions.

Actually, the true incidence of perforation may be higher, because some perfrations are asymptomatic and never identified.

Although the device may migrate or be dislodged at any time, it is generally agreed that perforations most commonly occur or at least begin at the time of insertion.

Persons who have less experience in IUD. insertion or who neglect to use a forceps for straightening and stabilizing

the uterus and a sound for determining uterine depth and direction before insertion are more likely to cause perforation.

Apart from a faulty technique by the operator, there are other factors that may lead to perforation at the time of insertion such as; improper choice of the suitable loop for each uterus, traction on the anterior lip of the cervix of the anteverted flexed uterus which exposes the posterior uterine wall to be injured directly by the tip of the inserter or by the loop while emerging from it, and in correct loading of the loop in the inserter.

Pregnant or puerperal uteri may be more vulnerable than those that have recovered from any of such changes.

The perforations could be divided into two groups:

Group A: Those with complete passage of the device into the peritoneal cavity.

Group B: Those with uterine perforation but only with partial passage of the device into the peritoneal cavity.

No serious complications have been reported with extrauterine loops but intestinal obstruction could occur if a loop of small bowel were incorporated in the mass of the omentum or fibrous tissue which may eventually encapsulated

the device. It is also possible but not likely that the device could perforate the bowel or bladder as more rigid objects do. The diagnosis of perforation is based on combined clinical and radiological findings.

Clinically, in the absence of a history of expulsion, absence of the threads together with negative sounding of the IUD in the uterus lead to a provisional diagnosis of perforation which necessitated further investigations.

Plain radiography without and with traction on the cervix proved to be a valuable diagnostic method.

Hysterosalpingograms and fractionated hysterograms in the antero-posterior and lateral positions confirmed the presence of the perforated loop outside the uterine shadow.

There is some disagreement, however, as to whether open or linear devices should be removed.

Burnhill and others have advised leaving the device in the peritoneal cavity and inserting another in the uterus. Other investigators recommended that all devices which have perforated must be removed.

Recent reports suggest that removals may be attempted where feasible by laparoscopy or culdoscopy and otherwise by laparatomy or colpotomy.