THE VALUE OF THE HYSTEROSCOPE IN MANAGEMENT OF MISSED INTRAUTERINE CONTRACEPTIVE DEVICE

THESIS

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By

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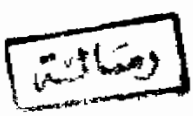

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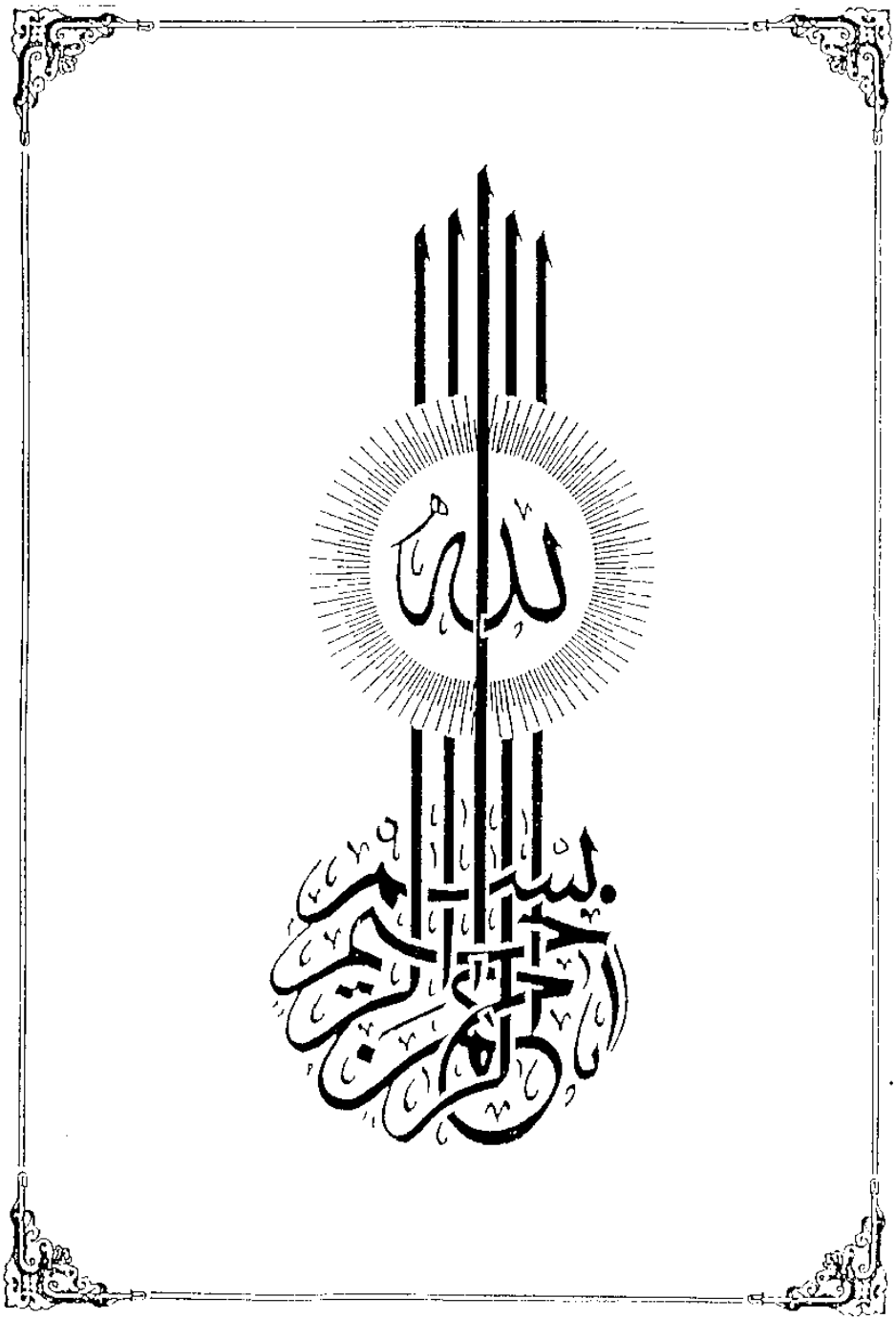

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A C K N O W L E D G M E N T

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I N T R O D U C T I O N

Introduction

The use of the IUCD has increased more rapidly during the past decade than the use of any other contraceptive method and has now become a major method of contraception in family-planning programmes in many parts of the world. with as many as 60 000 000 women currently using it. (Van Os, 1983).

With the use of IUCDs for contraception, misplacement or embedding of these devices in the uterine cavity or the tearing or curling up of their filaments has become a common problem (Valk, 1983).

The incidence of this problem appears to be related to the experience of the clinician and, to some degree, to the timing of insertion. Since most perforation occur at the time of insertion. The rat of expulsion varies between 2% and 20% in the first year of use. Devices inserted in the postpartum and postabortion periods are reportedly more prone to expulsion. Half of the expulsions occur within the first three months following insertion. The device may be missing as a result of tail retraction into the uterus, expulsion, or perforation. The over all rate has been reported as 0.9/1000 insertions. (Grosline et al. 1985).

Verification of the position of the IUCD may be performed by invasively attempting to retrieve the IUCD

when no thread is seen or by attempting to image the IUCD by non-invasive radiologic means. Among the radiographic techniques that have been used to locate missing IUCDs are radiographs of the pelvis, radiographs after insertion of a metal probe into the uterine cavity and hysterosalpingography (Jouppila 1975).

Other methods have been used for the location of these misplaced IUCDs, as diagnostic roentgenography (Ansari, 1974), Ultrasonography (MC Ardle, 1978 and Reierstsen, 1981), Sounding or probing of uterine cavity and hysteroscopy (Valle et al. 1977). When IUCD thread has retracted, it can be extracted by D & C, hook under flouroscopy (Diaconis and Weiner 1974), small packing forceps (Wagner, 1983), hysteroscopy (Valle 1979) , Novak curette (Abromovici and Brandes, 1978) or Karman cannula (Goh, 1978).

Other methods have been used for removal of the perforated IUCD as Laparoscopic removal (Siegler,1973), removal by Laparotomy, Hysterotomy.(Liedholm, 1976), Hysterectomy (Liao, 1979) or posterior colpotomy(Burray 1978).

Hysteroscopy is a relatively new technique, not yet generally available, that has already shown itself of great utility in the visualization and removal of

IUCD., because of missing string or other reason, its presence is uncertain. It has the advantage of a procedure conducted under visual control as opposed to a "blind" procedure, such as intrauterine manipulation with uterine sound or D & C in which decisions are made from information based essentially on the tectile sensation transmitted to the fingers by the way of a metallic instrument. The sense of sight is obviously superior to the sense of touch in this regard. Although it was true that, on occasion, there may be failure to adequately visualize the uterine cavity, due to bleeding or technical in experience, the undeniable advantages remain.

Moreover, although general anaesthesia has been used previously, the more recent trend is to paracervical block, except when other procedures requiring general anaesthesia such as D & C or laparoscopy are contemplated. (Zakin 1981).

AIM OF THE WORK

Aim of the work:

The aim of this work is to evaluate and compare the results of using the hysteroscope, the plain x-ray and the ultrasonic in diagnosis of the missed contraceptive devices and also to evaluate and compare the success and safety of the hysteroscope and surgical dilalation and extraction in dealing with this problem.

REVIEW OF THE LITERATURE

Missed Loop

The term missed loop is used to define the cases in which the tail of the IUCD disappears from the vagina. This condition usually results from rotation of the loop inside the uterine cavity with pulling up of its tail. However it might result from unnoticed expulsion of the loop, perforation into the peritoneal cavity and pregnancy.

Unnoticed Expulsion:

The rate of the loop expulsion in most large studies ranges from about 5 to 20 per 100 women at one year. (Population report 1979). They are influenced by the age, parity of the user, timing of insertion, time elapsed from insertion to expulsion, and the size and nature of the device.

Tietze 1970, and Mishell 1978, independently, recorded that about 20 per cent of IUCD expulsions go unnoticed and approximately one third of pregnancies among IUCD users occur after unnoticed expulsion. They also recorded that more than 70 per cent of these expulsions occur in the first year after insertion with decreasing rate every year there after. The highest incidence of expulsion was reported throughout the first three months of use.