



Pregnancy With Teratoma& Missing Thread –A Threat

Dr. Selvarani Jeyaraman¹, Dr. G. Prema Priya²

¹Senior Consultant, ²Associate Professor,

Department Of Obstetrics And Gynaecology, St.Joseph Hospital/ Srii Amogam Hospital, Dindigul
Vinayaka Missions Kirupananda Variyar Medical College, VMRF(DU), Salem.

***Corresponding Author:**

Dr. Selvarani Jeyaraman

Senior Consultant, Department Of Obstetrics And Gynaecology, St.Joseph Hospital/ Srii Amogam
Hospital, Dindigul

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Abstract

Among temporary contraception, Intrauterine Copper Devices (IUCD) are the most widely used and highly effective method for spacing of births. Some risk factors of IUCD failure such as displacement of the device are well known. In event of pregnancy with IUCD insitu, patient may be concerned not only about the unwanted pregnancy but also if she decides to continue her pregnancy, about its outcome and the effect of IUCD on her health and that of the developing fetus. In pregnancy with IUCD insitu, the Copper T is better to remove if the filament is visible to minimize complications such as miscarriage, preterm labour, low birth weight baby and sepsis. However if the filament is not visible, it is better to leave it alone and is expected to expel spontaneously after birth. Dermoid cysts constitutes about 97% of teratoma. Its incidence is about 20-40% of all ovarian tumours in pregnancy. Here with we are presenting an interesting case of second gravida post caesarean pregnancy with IUCD insitu& lost thread with recurrent dermoid complicating pregnancy and its management.

Keywords: IUCD insitu, multiple dermoid, oophorectomy, teratoma

Introduction

Intrauterine copper devices(IUCD) are the most widely used long acting reversible contraceptive methods. The pregnancy rate with IUCD insitu is about 2 per 100 women years of use. Lowest pregnancy rates are observed with CuT 380A (0.8-HWY), and LNG-IUS (0.2-HWY)¹. With IUCD insitu, the risk of ectopic pregnancy is 0.02%. IUCD should be preferably removed in the first trimester when its filaments are visible to reduce the likelihood of complications². Studies have shown that both filaments and IUCD itself cause infection³.

To continue her pregnancy with IUCD insitu, there are two options in an antenatal woman:

- IUCD can be left insitu - after counselling about the following risks

1. Spontaneous miscarriage (according to Tatum et al- 50%)⁴.
2. PROM
3. Premature labour
4. Infection

- IUCD can be removed under Ultrasound or Hysteroscopic guidance

The precise management of pregnancies in association with **lost IUCD's** and especially the technique of their removal has remained controversial. We present here, our experience on management of intrauterine pregnancy with an IUCD insitu with lost thread.

Dermoid are most common slow growing ovarian neoplasms (benign mature teratomas). Mostly asymptomatic and around 10% are detected during pregnancy. Constitutes about 20-30% of all ovarian

tumors in pregnancy⁵. Ovarian torsion, peritonitis from rupture and spillage of sebaceous contents, bowel obstruction and malignant transformation can occur⁶⁻⁸. Coexisting pathologies in a single organ present a challenge to the clinician. Here we present a case of G2P1L1/previous LSCS with IUCD insitu with a lost thread and recurrent dermoid complicating pregnancy. Coexistence of IUCD insitu with lost thread and dermoid in a pregnancy prompted us to report this case.

Case Report:

A G2P1L1/Previous LSCS with history of 49 days amenorrhoea presented to obstetric OPD with positive pregnancy test. She gave history of interval IUCD insertion after first delivery. She also gave history of missed IUCD thread on self examination. She is otherwise asymptomatic. She had history of bilateral ovarian cyst excision during her previous caesarean section which proved histologically mature cystic teratoma. Her vitals were stable with per abdomen– soft, non tender, suprapubic scar. On speculum examination, the IUCD strings were not visualized. She was advised transvaginal ultrasound which showed **Single live intrauterine gestation** of 7 weeks with IUCD located just outside the gestational sac right laterally with B/L recurrent Dermoid cysts (Figure 1). Patient counselled about the risk of continuing pregnancy with IUCD insitu , the risk of miscarriage while removal and the

complications of dermoid in pregnancy. Because of religious inhibitions she refused medical termination of pregnancy and wants to continue pregnancy with IUCD removal in spite of all complications. Hence proceeded with IUCD removal under ultrasound guidance after consent. Multiple attempts were made to remove the IUCD and were unsuccessful. Patient was then scheduled for IUCD removal under intravenous anaesthesia in operating room. The procedure went uneventful and the IUCD (Cu T 380A) was removed successfully. Post operative fetal viability assured. She was advised regular antenatal visits. Her subsequent antenatal period was uneventful. She underwent repeat elective caesarean section at 38 weeks of gestation and delivered an alive term baby boy of 3.2 kg with a turn of cord tightly encircled in the neck. Intra operatively dense omental adhesions, enlarged left ovary with multiple dermoid cysts noted and proceeded with left oophorectomy with left fimbriectomy and right tubectomy. Post op period was uneventful and patient discharged in good condition. Her histopathological report revealed 7×4×4 cm with fat and cheesy contents; a sclerotic nodule(umbo) in the wall-with a cartilage-cyst wall shows a leathery consistency with hair, also seen in the fimbrial end of the left fallopian tube. Sections of left ovarian tissue and cyst showed a benign dermoid cyst (mature cystic teratoma) with ectodermal, endodermal and mesodermal derivatives (Figure 2).

Figure 1 USG showing SLIUG with IUCD insitu and Bilateral Dermoid

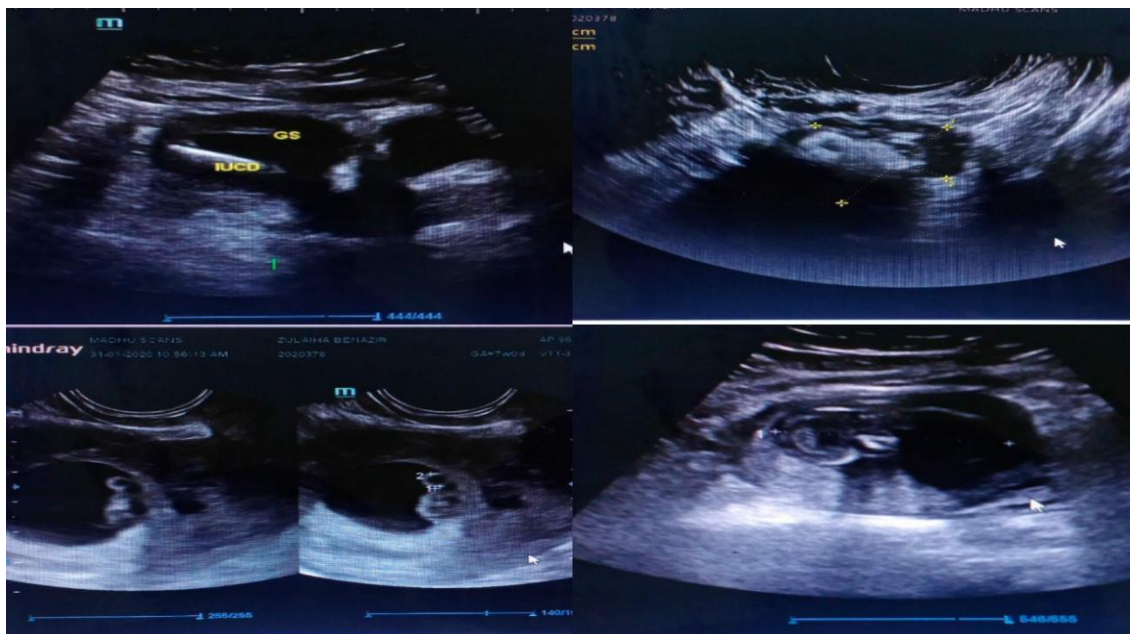
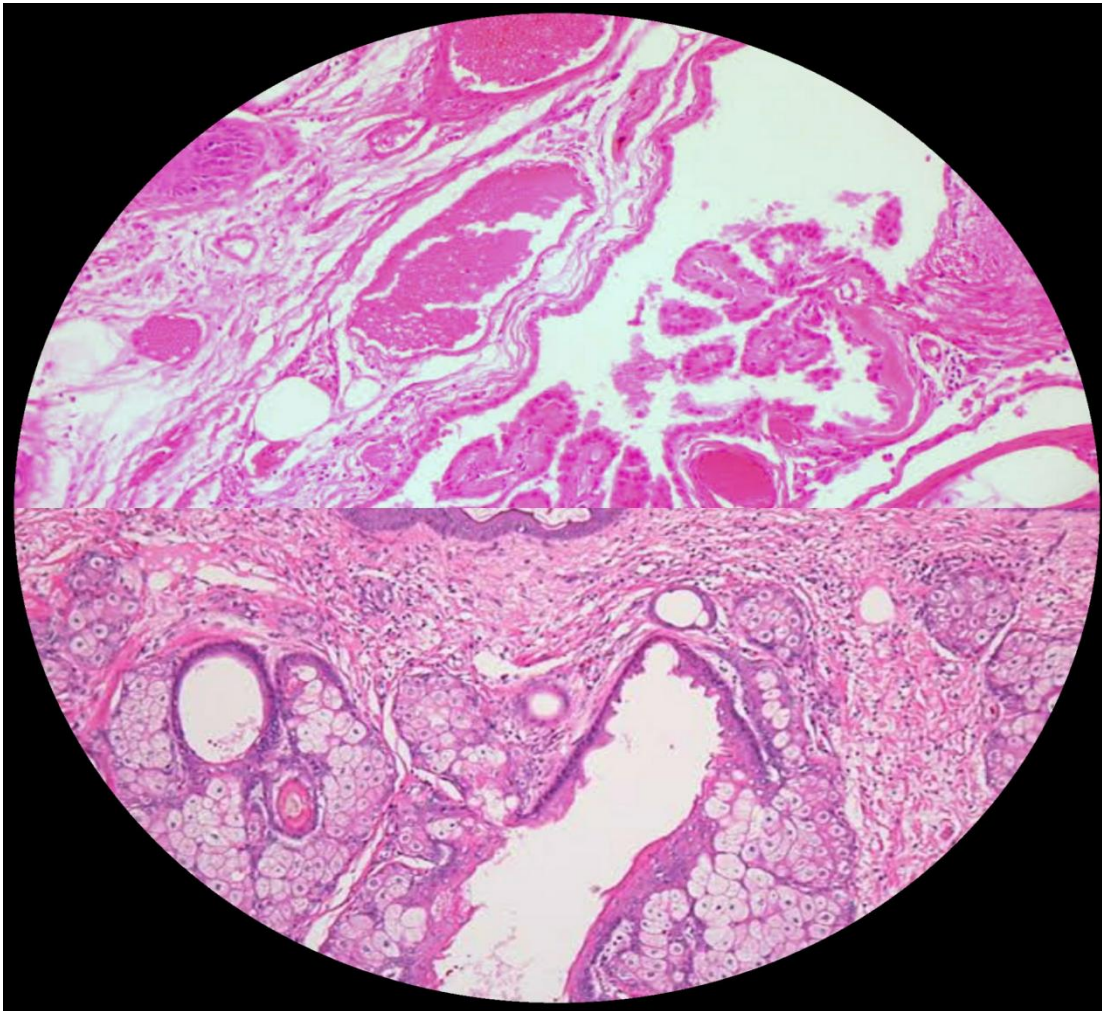


Figure 2 Histopathological image of mature cystic teratoma of ovary



Discussion:

In spite of good pearl index, the contraceptive failures are unavoidable. Pregnant woman with IUCD insitu are at increased risk of first and second trimester miscarriage, preterm premature rupture of membranes, chorioamnionitis, ascending fetal infection or maternal septicaemia⁹. According to studies

MMR due to septicaemia is 5 times higher in cases with IUCD insitu.

Increased risk of preterm delivery is 4 times higher with IUCD insitu^{1,10}.

Increased risk of miscarriage is 3 times higher with IUCD insitu.

The removal of IUCD decreases the rate of miscarriage from 48.3% to 29.6%. Based on the present data, ultrasound guided extraction of misplaced IUCD is better as it is minimally invasive, easily practicable with high degree of safety for ongoing pregnancy.

Dermoid arises from the germ cell – arrested after first meiotic division. It has a lower malignant potential, rarely grow more than a melon. While most ovarian cysts are benign, the management of the cysts becomes complicated mainly during pregnancy. Cyst removal at the time of caesarean section is an option for conservative method. Surgical approach ranges from cystostomy to cystectomy and possible oophorectomy. Ideal time for surgical approach is completion of first trimester.

Conclusion:

There is a need for prospective investigation on misplaced IUCDs, especially for women with scarred uterus, the weakened scar may lead to migration of IUCD. If a patient has lost IUCD and threads are not visible during pelvic examination, preoperative vigilance including transvaginal or transabdominal ultrasound or radiographs should be obtained to confirm the position of IUCD. Ultrasound guided extraction of IUCD is minimally invasive and inexpensive procedure, with a high success rate, moderate miscarriage rate and no maternal complications. Knowing the majority of ovarian cysts in pregnancy are benign and resolve spontaneously, management is usually conservative with serial ultrasound monitoring. Decision for surgical management of ovarian tumors should outweigh the risks for adverse perinatal outcome. In these regard it is better to avoid surgery in the first trimester and ideal time for intervention is between 14 to 22 weeks of gestation. With proper planning, management and expertise the pregnant woman with ovarian cyst can have a good maternal and fetal outcome.

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