Letters to the Editor

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Please include your complete address, e-mail address, and telephone number. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors.

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Case Report: Risk of Uterine Perforation from IUDs Is Greatest During Postpartum Period

TO THE EDITOR: Uterine perforation is a rare but potentially serious complication of the levonorgestrel-releasing intrauterine device (IUD; Mirena); the incidence is estimated at 0 to 2.6 per 1,000 insertions.[1] Perforation typically occurs during IUD insertion, and symptoms can include abdominal pain and uterine bleeding. However, perforation can go unrecognized for months or years if asymptomatic.[1-3]

When recognized, an IUD that has perforated the uterus should be removed promptly because bowel perforation, obstruction, or adhesions can occur.[1,2] Also, a malpositioned IUD may not prevent an unintended pregnancy.[1-5] Although the levonorgestrel-releasing IUD can be inserted in a nonpregnant woman at any time, including immediately postpartum, the risk of perforation is greatest during the 12 weeks after giving birth and while the patient is lactating.[1,4-6]

We present the following case:

A 31-year-old woman (two pregnancies, one full-term delivery, one miscarriage, one living child) presented to a family medicine clinic 12 months after insertion of a levonorgestrel-releasing IUD with frequent, irregular, and increasingly heavy menstrual bleeding. She requested that the IUD be removed. It had been placed six weeks postpartum, and the patient was breastfeeding. Attempts to remove the IUD in the clinic were unsuccessful, and the use of abdominal and pelvic ultrasonography failed to locate it. Abdominal radiography revealed that the IUD was located in the right lateral pelvis *(Figure 1)*. Although it was loosely tangled in the right fimbria, it was successfully removed using laparoscopy. No uterine structural abnormalities were found.

Clinicians and patients should carefully weigh the benefits and risks of IUD insertion during the postpartum period. A follow-up examination four to 12 weeks after insertion is recommended to ensure correct positioning; patients may opt to use another effective family planning method until this examination has occurred.

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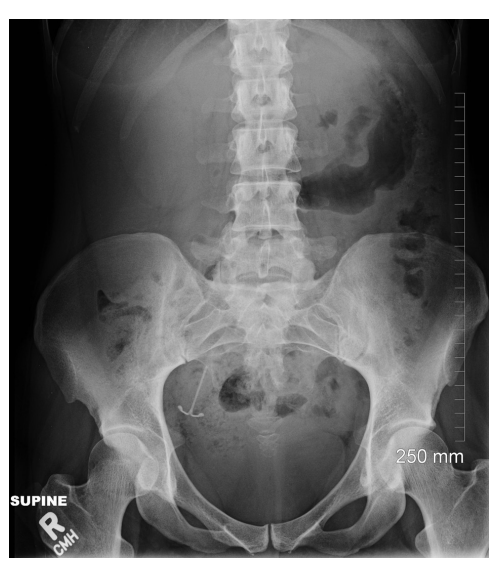

Figure 1. Radiograph showing intrauterine device in the right lateral pelvis.

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Corrections

Incorrect statement regarding clinical suspicion of a hernia. The article "Inguinal Hernias: Diagnosis and Management" (June 15, 2013, p. 844) contained an error in the last sentence of the first paragraph in the second column of page 845. The sentence should have read: "If the patient indicates that this bulge disappears while he or she is in the *supine* position, clinical suspicion of a hernia should be increased." The online version of the article has been corrected.

Error in testing interval for tuberculosis and dosing regimen for rabies, and missing information regarding measurement of neutralizing rabies antibodies. The article "Postexposure Prophylaxis for Common Infectious Diseases" (July 1, 2013, p. 25) contained several errors. In the first statement in the fourth column (Regimen) of the last row of Table 3 (p. 29), the statement should have indicated that a tuberculin skin test or interferon-gamma release assay should be performed at baseline and at eight to 12 weeks after exposure to tuberculosis, rather than one month after exposure. In Table 2 (p. 27), the recommended postexposure prophylaxis regimen for rabies in previously unvaccinated persons provided an incorrect dosing schedule. The dosing regimen should have been as follows: "Rabies vaccine should be given as early as possible on days 0, 3, 7, and 14 postexposure, in addition to human rabies immune globulin (20 units per kg in a single dose) on day 0. Rabies immune globulin should be infiltrated around the wounds first if anatomically feasible, with the rest administered IM into the gluteal region. If the person is immunocompromised, a fifth dose of rabies vaccine should be given on day 28." Additionally, there should have been a footnote about measurement of neutralizing rabies antibodies pre- and postexposure in previously vaccinated persons. The footnote should have read: "The level of neutralizing rabies antibodies pre- and postexposure should not be routinely measured except in immunocompromised persons, in persons at continuous high risk, and in persons who have received non–cell-based rabies vaccine." The online version of this article has been corrected. ■

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