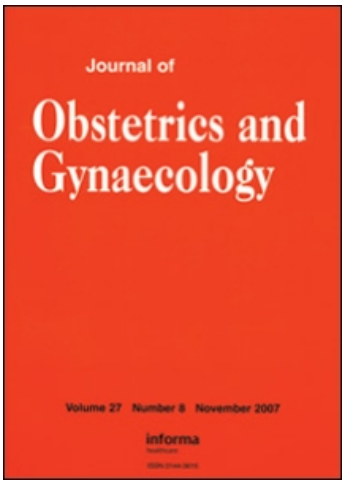

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Swinging pyrexia after hysteroscopy: An unusual complication

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advantages conferred by the laparoscopic route include the ability to survey the intraperitoneal cavity and secondly manage the retrieval under direct vision. This case demonstrates that laparoscopic removal of retained Redivac drain is safe and feasible. The safe perioperative management of drains necessitates: (a) knowledge of the anterior abdominal wall; (b) appropriate placement of the drain away from the wound edge; (c) use of blunt needles to minimise inadvertent damage to drains and (d) sound operative skills to minimise the need for drains.

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Swinging pyrexia after hysteroscopy: An unusual complication

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Case report

A 50-year-old woman presented with postmenopausal bleeding. Since menopause 2 years previously, she had never used hormone replacement therapy. She was petrified of pelvic examinations and had no smear performed since the 1970s. She had a coil inserted in 1978 after delivery, which had got lost in the uterine cavity.

An ultrasound showed a thickened endometrium at 13 mm and the coil positioned superior to the endometrium. At hysteroscopy the endometrium was fluffy and irregular and a Lippes Loop was seen partially embedded in the myometrium. This was removed and curettings sent for histology.

That evening she developed a swinging pyrexia up to 38.8 degrees, that was unresponsive over the next 6 days to cephalosporins, metronidazole and gentamicin. On examination, the abdomen was soft and non-tender. Bowel sounds were normal and the chest was clear.

She developed some painful white circumscribed lesions on either side of the midline on the tongue after 3 days.

The C-reactive protein was elevated at 159. A chest X-ray, midstream urine, blood cultures, high vaginal swab and a repeat pelvic ultrasound were all normal.

The histology from the endometrial curettings showed acute on chronic endometritis with colonies of actinomycosis.

She was started on parenteral penicillin and became apyrexial within 48 h. The tongue lesions healed within 3 days. She was advised to continue oral treatment with penicillin V for 6 months.

Discussion

Swinging pyrexia immediately following hysteroscopy is very unusual and raises concerns about complications of uterine perforation.

In our case, this was ruled out by the lack of pelvic symptoms and a normal pelvic ultrasound following hysteroscopy. Although inflammatory markers were raised, swabs and blood cultures failed to identify the cause, and the patient did not respond to standard antibiotic therapy.

The diagnosis eluded us until the histology came back showing colonies of actinomyces. The swinging pyrexia following hysteroscopic removal of the Lippes Loop embedded in the cavity for 28 years, was due to dissemination after curettage, of a hitherto localised focus of infection. With the use of the Mirena coil, actinomyces infection has become very uncommon, although the association of this gram-positive organism with older generation intrauterine contraceptive device (IUCD) use had been well documented in the past. The risk of infection is more when the IUCD is worn longer than 4 years (Cleghorn et al. 1989). Our patient had the Lippes Loop in for 28 years.

It is important to remember lessons learnt in the past, even if they are rare at present. We suggest that coils past their recommended duration of use be removed under antibiotic cover. Currently antibiotic cover during removal of an IUCD is recommended in symptomatic patients only (Hatcher et al. 2004). However, the only symptom in our patient was postmenopausal bleeding, which is a very atypical presentation of actinomyces infection, as pelvic infection and IUCD use is

associated with women in their reproductive years. Concerns at the time were about endometrial carcinoma rather than any unusual infection, and so a hysteroscopy was arranged, and the IUCD removed without antibiotic cover.

In retrospect, the thickened endometrium on ultrasound and fluffy irregular endometrium on hysteroscopy can be attributed to endometritis.

The other unusual feature in our case was the tongue lesions. Spread of actinomyces infection is usually direct through contiguous tissue planes. Haematogenous spread is rare (Burden 1989) but would be supported in our case by the appearance of the tongue lesions, which have been rarely reported. Although not proven by biopsy, these lesions responded promptly to penicillin therapy. Actinomyces responds poorly to cephalosporins and metronidazole, which is demonstrated by our case. The treatment is long-term penicillin therapy.

Actinomyces are occasionally identified on cervical smears but in an asymptomatic woman needs no treatment or IUCD removal (Lippes 1999). In a small number of cases, colonisation may progress to infection and cause pelvic inflammatory disease, usually endometritis, salpingo-oophoritis and rarely tubo-ovarian abscess (Burkman et al. 1982).

Definitive diagnosis, as in our case is usually based upon histological identification of actinomycotic sulfur granules or culture of actinomyces (Burden 1989). Sulfur granules represent colonies of actinomyces and are characterised by a zone of granulation tissue surrounding one or more oval eosinophilic granules.

In summary, our patient developed an unusual swinging pyrexia post-hysteroscopy, which was diagnosed following histology, as dissemination of actinomyces endometritis.

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Ileal penetration and tubo-ovarian abscess in the presence of an intrauterine device

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Case report

A 32-year-old gravida 8, para 7 menstruating, sexually active woman had a multiload-Cu 375 for 3 years inserted in her 3rd month postpartum visit. She described a difficult and painful procedure for insertion of the intrauterine device (IUD). The discomfort after insertion lasted for 5 days. She was admitted with abdominal pain, vomiting and intermittent diarrhoea for 1 month. Physical examination revealed abdominal tenderness and a large, poorly delineated mass on the left lower quadrant of the abdomen. Initial laboratory evaluation revealed 8.11 g/dl haemoglobin and 14,500/mm^3 white blood cell count with 64% polymorphonuclear cells.

Pelvic ultrasound revealed a 5 × 5 cm complex mass on the left side of adnexum and, the IUD was seen in the uterine cavity, with the IUD threads invisible on vaginal examination. The patient underwent an operation for the management of a pelvic mass. The uterus was noted to have a perforation in the right posterior fundal wall. There were omental adhesions and ileal adhesions to the posterior wall of the uterus. After lysis of these adhesions, further dissection revealed the IUD penetrating through the full thickness of the bowel wall with two plastic arms and vertical copper-bearing limb (Figure 1). There was an abscess 5 cm in diameter on the left side of uterus. Wedge resection of an ileal segment with primary suture was performed and the drainage of the abscess was performed. At the postoperative period, the patient was treated with empiric penicillin and metronidazole treatment. Abscess material revealed *Ruminococcus productus*.

Discussion

The IUD is generally a safe modality for long-term contraception. The triad of abdominal pain, fever and intermittent diarrhoea associated with a missing IUD suggested bowel injury (Abdalla 1984). Interval between insertion and removal of IUD in the cases of ileal penetration is varying between weeks and years (Chen et al. 1998). In our case, the interval was 3 years. An ultrasound scan is generally useful in the diagnosis of a missing IUD but even in the presence of an ultrasound showing that an IUD is in the uterine cavity, this may in fact be