

Spontaneous Vaginal Expulsion of a Filshie Clip

Dear Editor,

Laparoscopic sterilisation is a common method of permanent contraception. The Filshie clip system is a safe and effective method of female sterilisation. Being used around the world for more than 20 years, this form of contraception continues to be the method of choice for many physicians and patients due to the ease and simplicity of application and minimal tube damage produced. Nevertheless, failures are known to have happened. The Royal College of Obstetricians and Gynaecologists' evidence-based guidelines recommended that the Filshie clip failure rate be quoted as 1 in 200.¹ One reason for failure is clip migration. We present a case where the migrated Filshie clip was expelled per vaginum.

A 32-year-old woman, who has 2 children, appeared at the gynaecology clinic, with a history of having passed a Filshie clip per vaginum the previous night. She had undergone post-partum sterilisation via a mini-laparotomy 5 years ago. The procedure was uncomplicated and the post-operative period was uneventful. Now, 5 years later, during her menstruation, the woman passed out the clip per vaginum. She brought the clip to the clinic; it was still in a locked position. During examination, no defect was found in any of the vaginal fornices; but there was 1 tender spot in the posterior fornix. A hysterosalpingogram was arranged for her. The abdominal cavity was surveyed under fluoroscopy prior to dye injection. Only 1 Filshie clip was noted in the entire abdominal cavity. This was in the right hemipelvis. After Lipoidal injection, there was opacification of both the fallopian tubes but there was no spillage into the peritoneal cavity (Fig. 1). The remaining Filshie clip was noted to be off the tube and in a closed position. The patient was informed of these findings. She elected to do nothing despite counselling that she might be at risk of getting pregnant again.

Sterilisation is a common mode of contraception for women who have completed their families. The Filshie clip system has been used for female sterilisation for more than 20 years. Rioux and Yuzpe² have reported an overall failure rate of 0.27% for interval procedures and 0.9% for post-partum procedures.

The Filshie clip, made of titanium, is lined with silicon rubber. After the clip is applied over the fallopian tube, the soft silicone lining is compressed. The part of the tube between the jaws of the clip undergoes avascular necrosis. The silicone then expands to keep the lumen closed. Over time, peritoneal tissue grows over the clip, thereby holding the clip in place. Occasionally, this process of perito-

nealisation is delayed and the clip may then fall off and migrate as the healed and sealed tubal ends separate. As the Filshie clips migrate when the tubal ends have already been occluded and separated, failure of sterilisation is unlikely to occur.

It is estimated that this kind of clip migration occurs in over 25% of the patients.³ A majority of these clips will migrate to the pouch of Douglas, the paracolic gutters or the omentum. Filshie clips lying loose in the pelvis have been detected during subsequent laparoscopy or laparotomy in women who have previously undergone tubal ligation. Amu and Husemeyer⁴ have published a review article on migration of Filshie clips and Hulka clips. No serious sequelae were noted.

It is not a routine practice to inform women, who opted for this procedure, that this harmless complication may arise. That is why during rare occasions of clip expulsion – as in this case – the patient understandably experiences a lot of anxiety. It may be considered by such women as proof of sterilisation failure. It is, therefore, important to evaluate the tubal patency with a hysterosalpingogram. If the tubes are found to be patent, alternative contraception needs to be discussed. We did not do any further evaluation or treatment after the hysterosalpingogram confirmed the lack of tubal patency as the woman declined further treatment.



Fig. 1. Hysterosalpingogram-delayed film showing absence of spillage on both sides. Also note that the right Filshie clip is off the fallopian tube.

After taking into consideration all the evidence, we feel that the risk of clip migration is higher than generally acknowledged. Even at half the 25% risk quoted by Filshie,³ it is something that women need to be told about at the time of preoperative counselling. At the same time, they also need to be reassured that serious sequelae are unlikely in the event that clip migration occurs. Also, it is equally important to stress that clip migration does not mean failure of sterilisation procedure. Taking note of this not so uncommon phenomenon may alleviate the already high risk of litigation associated with this procedure.

REFERENCES

1. Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG), 2004:11. Evidence based Clinical Guideline no. 4.
2. Rioux JE, Yuzpe AA. Modern approaches to female sterilization. *Contemp Obstet Gynecol* 1997;42:92-103.
3. Filshie GM. Long-term experience with the Filshie clip: review article. *Gynaecol Forum* 2002;7:7-10.
4. Amu O, Husemeyer RP. Migration of sterilisation clips: case report and review. *Br J Fam Plann* 1999;25:27-8.

Anita Kale,¹*MRCOG, MD*, Yap-Seng Chong,²*MRACOG, MD*

¹ Department of Obstetrics and Gynaecology, National University Hospital, Singapore

² Department of Obstetrics and Gynaecology, Yong Loo Lin School of Medicine, National University of Singapore, Singapore

Address for Correspondence: Dr Anita S Kale, Department of Obstetrics and Gynaecology, National University Hospital, 5 Lower Kent Ridge Road, Singapore 119074.

Email: anitakale@hotmail.com