The migrating Filshie clip to the inguinal canal posing as an endometrioma: the untold imposter of female sterilisation

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The Case

- 40 year old
- Normally fit and well
- Para 3 (all NVD)
- Normal smear Hx
- PMH: laparoscopic sterilisation 2004
Laparoscopic sterilisation 2004
GP referral to surgeons

- 1 year Hx of RIF pain & painful right inguinal lump
  - ? Direct inguinal hernia

- 2 x 2 cm firm mass in medial inguina
  - No cough impulse
  - Non-reducible

- ? Direct hernia but atypical on palpation
  - USS confirmation
USS right inguina
MRI pelvis
Referral to Gynaecologist

- 2 year Hx of RIF pain & painful right inguinal mass.
  - Tearful
  - Vomits with pain
- Increasing in size and increased tenderness with menstruation
- Menorrhagia – 4/23 day cycle
- Deep dyspareunia
- No Hx of PID. No post-coital/IMB
- Impression: 2° dysmenorrhoea 2° to endometriosis with a right inguinal endometrioma
Diagnostic laparoscopy
Laparoscopic adhesiolysis
Inguinal Canal dissection
“All of the tissue has been embedded. Sections show dense collagenous connective tissue and fat. There is focal chronic inflammation. There are no specific features of note.”
Normal Hysteroscopy

- Mirena IUS inserted

- Good post-operative recovery with resolution of symptoms at 6 weeks
Laparoscopic tubal occlusion with Filshie clips is a popular method of permanent contraception.

- Used by > 82% of surveyed Gynaecologists in UK¹

Failure rate 0.5%²

12.7 mm x 4 mm titanium clip with silicone rubber jaw lining

- Causes tubal avascular necrosis
- Clip usually becomes peritonealised and remains *in situ*
Discussion

- Delayed peritonealisation gives opportunity for migration
  - 25% migrate off tubes – normally within peritoneum\(^3\)
  - Amu and Husemeyer\(^{10}\) reviewed Filshie and Hulka clips migrating to peritoneum – no serious sequelae reported.
    - 0.6 in 1000 migrate through tissue plains\(^{4,5}\)
      - Common sites include:
        - Urinary bladder.pdf\(^4\)
        - Uterus and vagina.pdf\(^7\)
        - abdominal wall-groin sinus.pdf\(^8\)
        - rectum.pdf\(^9\)
    - Complications including abscess formation, fistulisation and pain. 10 months – 13 years.
Pathogenesis

- Studies in primates suggest foreign body inflammatory response\(^6\)
- Clinically evident with:
  - Adhesion formation around dislodged clips at laparoscopy
  - Ectopic pregnancy following sterilisation with tubo-peritoneal or tubo-tubal fistula formation
- Peritoneal inflammation from a low grade foreign body inflammatory response with subsequent adhesion formation is therefore a possible explanation for clip migration through tissues
Conclusions & Dilemas

Small but significant literature base – mostly from case reports – of Filshie clip migration

Pre-operative consent
- Significant risk of migration off tubes (approx 25%)
- Rare risk of migration through tissue plains (0.6 per 1000) – not all of which will cause symptomatic complications (i.e. Cases of expulsion)

Contraception
- Investigation or additional contraception not routinely recommended.
- Age, duration post tubal occlusion, patient anxiety may indicate need for hysterosalpingogram?

Filshie clip migration considered in differential diagnosis of pelvic pain and/or superficial abdominal mass – particularly 7-10 years post sterilisation
References

5. United States Food and drug advisory panel meeting; 26th February 1996 [Link](#)
Any Questions/comments?

Thank you