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Filshie clip migration: A report of two cases

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Introduction

Since its introduction in 1981, the Filshie® clip (CooperSurgical, Trumbull, USA) has been widely accepted as safe and effective. Failure rates reported in the literature range from 0.23 to 0.40% (Penfield 2000). Very few problems have been reported in its 30-year existence, it is estimated that 25% of patients eventually experience clip migration, but only in an estimated 0.6 per 1,000 patients does this migrated clip cause symptoms or be expelled (Kesby and Korda 1997). We report on two cases with extra-peritoneal migration.

Case report 1: Vaginal expulsion

A 40-year-old woman (P2/H110010) presented with a 3-day history of pain of sudden onset, felt inside the vaginal canal, but also over the medial aspect of her right thigh.

Her medical history included a laparoscopic sterilisation using Filshie® clips 8 years earlier, and a vaginal hysterectomy for fibroids 4 years ago. Her records noted that Filshie® clip placement was uneventful, but correct placement of the clips was not photographed. At the vaginal hysterectomy, it was noted that the clips were still attached to the fallopian stumps. This procedure was also uneventful.

The woman’s complaints began with a burning sensation in the vagina, dyspareunia and dysesthesia of the right upper thigh. On gynaecological examination, a greyish nodule was noted in the upper vaginal wall, on the right hand side (Figure 1).

She was admitted for surgery and had the clip removed, under general anaesthesia, by an incision in the vaginal wall and extirpation of the clip with forceps. Upon removal, it was noted that the clip’s jaws were still tightly locked. Her recovery was uneventful and she is now pain free.

Case report 2: A migrating clip causing shoulder pain

A 48-year-old woman (P2+0), presented with pain of sudden onset in her right shoulder.

Her history included two uneventful vaginal deliveries 13 years and 11 years earlier, and a laparoscopic sterilisation using Filshie® clips 8 years before her current presentation. In her records, the sterilisation was reported to be without complications, but correct placement of the clips was not photographed.

The woman experienced a sudden pain felt over her right shoulder, in the C3–C4 dermatome. Symptomatic treatment with paracetamol did not bring any relief. After 3 weeks, an X-ray of the thorax was taken, where a Filshie® clip was noted lying against the right hemidiaphragm. She agreed to an initial expectant approach, and the pain spontaneously ceased after 6 weeks. A repeat X-ray 4 years later, when she was symptomless, showed that the clip was still located in the same region (Figure 2).

Hysterosalpingography was not done, out of fear of fistulisation and ectopic pregnancy.

Discussion

Previous case reports of complications include migration of a clip and expulsion through the abdominal wall (Tan et al. 2004), via the anus (Pandit 2005), vagina (Kale and Chong 2008), and urethra (Connolly et al. 2005), or a migrating clip presenting as chronic groin sinus (Kolias et al. 2010) or chronic peri-anal sepsis (Dua and Dworkin 2007; Hasan et al. 2005). Expulsion has occurred as early as...

Figure 1. (A) Clip in vaginal wall. (B) Removal, jaws locked.
6 weeks after application (Pandit 2005) and as late as 21 years (Kolias et al. 2010). The mechanism of migration is thought to be as follows: the clip, when correctly placed on the fallopian tube, induces avascular necrosis of the occluded part, thus leaving two blind stumps. Normally, the clips remain attached to one of the blind ends of the tube, and are then gradually covered by peritoneal growth. If this growth fails to occur, the clips may fall off. They usually reside symptomless in the pouch of Douglas or in the paracolic gutters. Only a few case reports exist of migrating Filshie® clips causing discomfort. The process of migration and expulsion is believed to be driven by low-grade inflammation, as histology reports of excised tissue containing migrating clips have confirmed (Connolly et al. 2005), although this mechanism is questioned by YellamareddyGari et al. (2005) as a response to Pandit’s case study (Pandit 2005), where an abdominal X-ray confirmed the intra-abdominal location of a clip, 1 week before its expulsion through the anus. Could an inflammatory process induce migration so quickly? If not, what other possible mechanism could explain such a fast process? Would it be more plausible to assume that at the time of the abdominal X-ray, the clip was already penetrating the sigmoid wall? Our two patients experienced discomfort due to a dislocated clip, both 8 years after the correct clip placement, which could fit in a theory of long-term, low-grade inflammation causing migration.

**Conclusion**

These case reports show once more that, while Filshie® clip migration causing discomfort is a rare phenomenon, one has to bear the possibility in mind in a patient with unexplained pain and a Filshie® clip sterilisation in her medical history.

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**References**


