

# FEMALE GENITAL MUTILATION AN UNEXPECTED ENCOUNTER

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## Introduction:

Any non-medical intentional alteration or causes injury to female genital is termed female genital mutilation (FGM). This procedure typically performed by the traditional circumciser on young girls between infancy and 15-year-olds.

FGM is recognized as harmful procedure with no medical benefit but still remains prevalent in some countries in Africa, Middle East and Asia. Each year, more than 3 million girls worldwide are at risk of undergoing FGM<sup>1</sup>. Herein, we would like to share a case of a young patient presented to us with acute urinary retention secondary to scarred tissue from an un-intentional Type 3 FGM since young.

## Case Report:

A healthy 20-year-old nulliparous lady presented with acute urinary retention. She has reached menarche at 15 years old with normal menses flow and currently on day 1 of menses. She had a similar presentation few months ago and was treated as urinary tract infection in Emergency & Trauma Department (ETD).

On examination, she was in apparent good health and her vital signs were stable. Her abdomen was soft with a palpable bladder. Examination of the external genitalia revealed a fused labia majora with a small opening sizing 0.5cm within the introitus. Trial of CBD insertion was unsuccessful as the external urinary meatus was not visualized. The rest of the systemic examination was unremarkable. Bedside ultrasound showed a large hypoechoic mass measuring 7x9 cm resembling a haematocolpos (Figure 1).

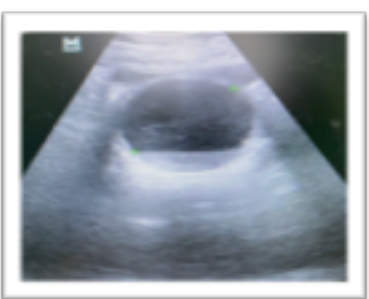


Figure 1: Haematocolpos on Ultrasound

Patient underwent examination under general anesthesia revealing a thick scarred tissue extending from clitoris area to 4cm above anus with fused labia majora. Separation of the fused labia majora was done until the original anatomical site of clitoris was exposed superiorly and introitus inferiorly. The urethral meatus was in the normal position, however there were absence of clitoral hood, clitoris and labia minora.

Further history from patient's mother, patient was circumcised at 2 months old by local midwife without proper medical training. It was believed that during the procedure unintentional FGM type 3 was performed.

**“Awareness for a more respectful & cultural sensitive approach when dealing with the physical and psychological consequences of these patients.”**

## Discussion:

FGM is performed for various cultural, religious and social reasons within communities where the practice of this belief could benefit the girl in some way. In 1985, World Health Organization (WHO) classified FGM into 4 main types based on the extend of cutting<sup>1</sup> (Figure 2).

Type 1: Partial or total removal of clitoris and/or prepuce.

Type 2: Partial or total removal of the clitoris and the labia minora with or without excision of the labia majora.

Type 3: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia (infibulation).

Type 4: All other harmful procedures to female genital including pricking, piercing or cutting.

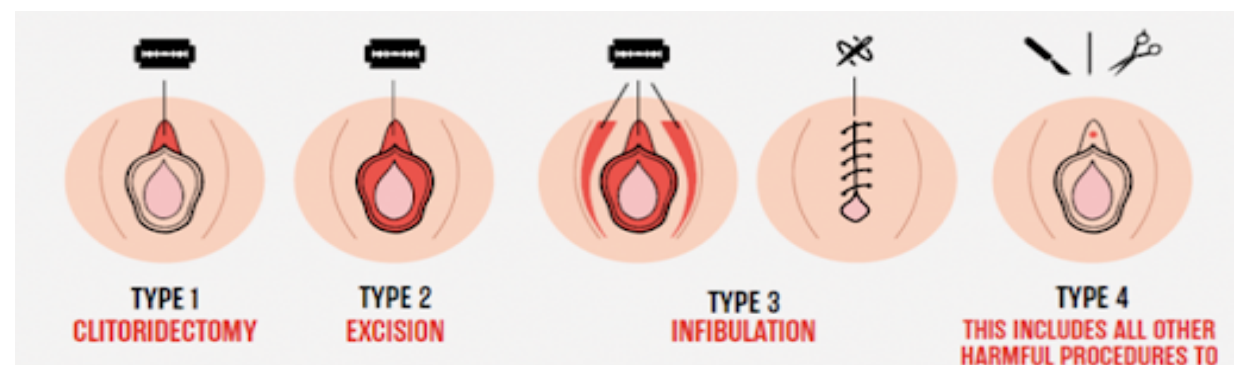


Figure 2: Different Types of FGM.

While at least 200 million women living today worldwide had undergone this procedure<sup>1</sup>, knowledge of FGM is limited among healthcare workers with most unable to recognize the 4 types of FGM<sup>4</sup>. The reason behind this is there are no accessible educational resources and clinical guidelines that are specifically focused on occurrence of FGM; its recognition, diagnosis, complications and management options<sup>4</sup>. Hence, the correct diagnosis of this patient was missed during the first visit to ETD.

FGM is often performed by traditional circumciser and often leads to complications physically and psychologically<sup>1</sup>. Complications related to FGM include urinary complications, scarring, infection, sexual dysfunction and obstetric difficulties. Complication rates vary according to the type of FGM performed and more frequently seen with Type 3 FGM.

Our patient most probably underwent Type 3 FGM which complicated with scarring. The scar tissue fused the labia majora by creating a covering seal, leaving a small opening (0.5cm) in the vaginal introitus. She was having her monthly menses though the small opening. Unfortunately, over time this leads to formation of hematocolpos on the day of heavy flow, which subsequently caused acute urinary retention owing to the pressure effect to the bladder and urethra.

FGM alone or labial fusion as a result of FGM may in turn lead to hematocolpos, which has been documented in 7% of women in one study<sup>4</sup>. Poor urinary flow and recurrent urinary tract infections have been reported in up to 22% of women following FGM and are thought to be due to obstruction of urethral opening by scar tissue sealing the vagina<sup>3</sup>.

Treatment of FGM Type 3 is by de-infibulation. It involves incising the fused labia minora to restore the introital opening<sup>2</sup>. More extensive plastic reconstruction of the external genitalia may be warranted in some instances, but was not necessary in our patient.

## Conclusion:

FGM might not be an everyday occurrence in the ETD. Awareness should be created in order to built a more respectful and cultural sensitive approach when dealing with the physical and psychological consequences of these patients.

## Acknowledgements:

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All the authors declare that there is NO CONFLICT OF INTEREST.

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