CLINICAL IMAGES

Urinary catheterization and female genital mutilation

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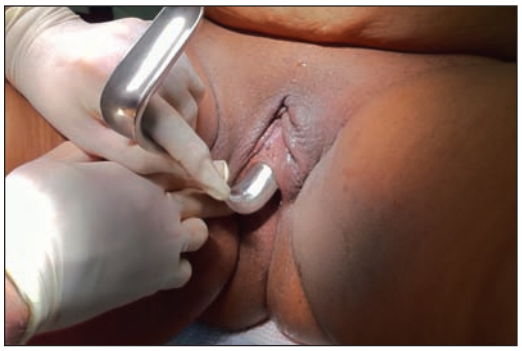

Figure 1: A lubricated Sim speculum is passed underneath the scar tissue in a 30-year-old pregnant woman with type III female genital mutilation.

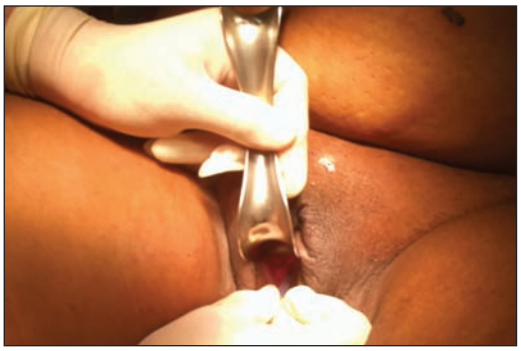

Figure 2: The Sim speculum is lifted upward to expose the urethra and allow insertion of the catheter.

A 30-year-old African woman was admitted in labour at 37 weeks' gestation of her fifth pregnancy for emergency cesarean delivery. This was her first assessment for the current pregnancy at this hospital. She had a cesarean delivery with each of her previous pregnancies. On examination, she was found to have type III female genital mutilation that had been done during childhood.

She required urinary catheterization, which was performed by cleaning the genital area with antiseptic solution, inserting a lubricated sterile Sim speculum underneath the scar (Figure 1), pulling the speculum outward, and then lifting it in an upward direction to expose the urethra for cleaning with antiseptic solution and insertion of a Foley catheter under direct visualization (Figure 2). Routine cesarean delivery under general anesthesia was done without complications.

The World Health Organization estimates that between 100 and 140 million girls and women worldwide have experienced female genital mutilation, and around 3 million girls undergo some form of the procedure each year.[1] Type III female genital mutilation (also known as infibulation) is defined by the World Health Organization as narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.[1] The complications associated with this procedure are well documented.[2]

Inserting a catheter into the urinary bladder can be difficult in women who have had female genital mutilation, particularly type III, in which the scar tissue covers the urethral meatus and part of the vaginal introitus. In emergency situations in which urinary catheterization is required,[3] the technique described above can be used to allow access for the urinary catheter (Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.111588/-/DC1). Defibulation (i.e., cutting the scar tissue) is another option.[4]

References

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4. McCaffrey M, Jankowska A, Gordon H. Management of female genital mutilation: the Northwick Park Hospital experience. *Br J Obstet Gynaecol* 1995;102:787-90.

See the following videos online:
Appendix 1: Insertion of a urinary catheter for a patient with female genital mutilation.
www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.111588/-/DC1.

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