

Case Report

Type 3 female genital mutilation; A rare cause of urinary retention in adult age

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Abstract

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Urinary retention is an inability to urinate due to mechanical or functional reason. It is a common urological pathology and the ratio of females to males is about 10/1. One of reasons of urinary retention that has been rarely observed in females is the female genital mutilation that continues to be commonly implemented in underdeveloped societies. In our case, 16 years old female with type 3 genital mutilation had difficulty in urination for a long time. It was learned that case sometimes had problem of glob vesicale as a result of urinary retention and temporal catheterization was implemented since she was inability to urinate. She was hospitalized by performing transurethral catheterization. Discussion of this situation causing many iatrogenic complications after female genital mutilation that has been implemented in poor societies at the present time was aimed via case of which suitable surgical operation and urogenital anatomy were provided.

Keywords: Adult age, Deinfubilation, Infubilation, Type 3 genital mutilation, Urinary retention

INTRODUCTION

Acute urinary retention, the sudden inability to urinate is a medical emergency, which is characterized by pain and distension of lower abdominal region (Emberton and Anson, 1999). In management of acute urinary retention, bladder should firstly be emptied by means of catheter and it should be set patient at ease. Afterwards, further urological investigations should be carried out in order to investigate the underlying pathology of urination

disorders (Thomas et al., 2004). Female genital mutilation is the removal of some or all of the external female genitalia due to traditional reasons mostly. According to World Health Organization data, from 100 to 140 million females around the world have been affected by this application (Adam et al., 2010). Female genital mutilation was classified into four types by World Health Organization in terms of degree of damage in external



Figure 1. Appearance of urogenital region in preoperative.



Figure 2. Appearance of genital region after operation.

genital organs (Adam et al., 2010).

Type 1-Partial or total removal of the clitoris and/or the prepuce (Sunna).

Type 2-Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (Circumcision).

Tip 3- Narrowing of the vaginal orifice with creation of partial or total removal of all genital organs (infibulation).

Tip 4- including all other harmful procedures such as piercing, cauterization of clitoris, amputation of vagina.

Type 1 and 2, the most frequent types, are seen as 80%, while type 3 is found as 15% (Onuh et al., 2006).

Severe bleeding, difficulty in urination and monitoring shock status can be listed from among early period complications of this traumatic process (Wadesango et al., 2011; Mandara, 2004).

The frequency of adherences, keloids, epidermoid

inclusion cysts and clitoral neuroma in genital area in consequence of genital mutilation is quite frequent in type 1 and 2. In these females, the risk of prolonged labor increases markedly and therefore dead birth and obstetric fistulas can be formed (Kaplan et al., 2013). Females with genital mutilation have severe bleeding depending on labor, requirement of episiotomy, caesarean section and prolonged hospital stay when compared to uncut females. Also, perinatal mortality rate of patients in this group is higher than those in groups that are not circumcised (World Health Organization, 2006). In this study, in consideration of up-to-date literature informations, we aimed to discuss case with urinary retention recurring frequently and depending on adhesions in genitourinary area secondarily developed with type 3 female genital mutilation in a 16 years old Sudanese female patient that applied to urology clinic.

Case

16 years old single female patient admitted to urology polyclinic with complaint of difficulty in urination continued for a long time and catheterization had to be performed before due to sometimes glob vesicale. After case was hospitalized, 1200 cc urine with brilliant and normal colour was emptied by transurethral catheter. It was observed in external genital examinations of case that she has been circumcised since 9 years old and infibulation vaginal orifice was quite narrow depending on adhesions (infibulation) (Figure 1). The examination of case in terms of other systems was normal but it was monitored that creatinine value (1.5 mg/dl) was close to upper limit. Pathology was not detected in case by urinary ultrasonography. Bladder was evaluated as normal in case by cystoscopy. Deinfibulation was planned to be done in patient. Introitus was enlarged by making incision from middle of labia minora leaves united at middle centre to upward (Deinfibulation) and wound lips was sutured by using polygalactia sutures (Figure 2). It was observed that patient whose transurethral catheter was removed urinated easily on post operative second day. Case was discharged from hospital without complications.

DISCUSSION

Female genital mutilation affecting profoundly health of woman and child and having physiological, sexual and psychological effects in the long term, is a harmful traditional application. According to UNICEF data, over 125 million females have been affected by this situation in geography especially from across Atlantic coasts to Africa and Iraq, Yemen and Middle East (9). People who migrated from these areas also continue this tradition in Europe and America continents (UNICEF, 2013). This application has been commonly encountered in all around world, particularly in 28 African countries where different ethnic origins are located (Berg and Denison, 2013). Most important factors in female genital mutilation are definitively religious and social pressures. The reasons such as socially approved, protection of virginity, suppression of sexual desire and religious disciplines are in the forefront in undeveloped countries (Pashaei et al., 2012). Many applications have been carried out in unhygienic conditions without anesthesia and mixtures of plants, cow dung and butter have been used for wound healing (Wadesango et al., 2011). Severe pain, bleeding, urinary retention, ulcers in genital area, adjacent tissue injury, sepsis and even death can be seen following procedures performed with scissors, part of glass, blade, bark, plant thorn by persons who do not medical professional training (UNICEF Innocenti Research Centre, 2011). Infections, keloids, genital tract infections, sexual inherited diseases, especially genital herpes,

increasing HIV infection risk, labor complications, sexual disorders and posttraumatic stress disorder can be listed for late period complications. Also, cases with type 3 female genital mutilation are more risky since complaints such as requirement of deinfibulation, frequent recurrence, re-requirement of surgery, urinary retention, menstrual problems and painful sexual intercourse are frequently seen (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Eliminating female genital mutilation: an interagency statement. Geneva, WHO 2008). The symptoms of lower urinary system are frequently seen in females type 2 and 3 female genital mutilation (Amin et al., 2013). Decreasing in urinary flow rate depending on infibulation causes urinary stasis and therefore causes repetitive urinary infections. Consequently, formation of urinary or vaginal stone can be seen (Yusuf and Negash, 2008). Recommended treatment method is the deinfibulation in these cases. urethral strictures or fistules can be seen depending on urethral trauma during mutilation. In our case, urinary retention depending on adhesions secondarily developed with mutilation was thought. It was observed that case urinated easily after deinfibulation operation. Cases with inability to have a sexual intercourse and therefore dyspareunia depending on improved vulvo-vaginal laceration and adhesions in genital region after female genital mutilation performed in unhygienic conditions was reported (Berg et al., 2014). It was thought that genital mutilation applications increase infertility associated with sexual disorders (Dyspareunia, apareunia) and genital infections. In case control study, it was stated that there was a relationship between primary infertility and female mutilation (Almroth et al., 2005). It was reported that psychological disorders such as secondary anxiety disorder and posttraumatic stress disorder in female genital mutilation can be seen (Behrendt and Moritz, 2005).

CONCLUSION

Female genital mutilation, affects profoundly female life and healthy in all over the world, especially African continent is a problem of public health. We are of opinion that recognition of this application and therefore related complications and treatment are important for raising quality of life in females affected by this tragic application and for arising of social awareness.

Conflict of Interest

Authors declare no conflict of interest.

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REFERENCES

- Adam T, Bathija H, Bishai D, Bonnenfant Y, Darwish M, Huntington D, et al., (2010). Estimating the obstetric costs of female genital mutilation in six African countries. *Bull World Health Organ.*;88:281–8
- Almroth L, Elmusharaf S, El Hadi N, Obeid A, El Sheikh MA, Elfadil SM, et al., (2005). Primary infertility after genital mutilation in girlhood in Sudan: a case-control study. *Lancet*;366:385–91.
- Amin MM, Rasheed S, Salem E (2013). Lower urinary tract symptoms following female genital mutilation. *Int J Gynaecol Obstet*;123:21–3.
- Behrendt A, Moritz S (2005). Posttraumatic stress disorder and memory problems after female genital mutilation. *Am J Psychiatry*;162:1000–2.
- Berg RC, Denison E (2013). A tradition in transition: factors perpetuating and hindering the continuance of Female Genital Mutilation/Cutting (FGM/C) summarized in a systematic review. *Health Care Women Int*, 34:837–859.
- Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE (2014). Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. *BMJ Open*;4:e006316.
- Emberton M, Anson K (1999). Acute urinary retention in men: an age old problem. *BMJ*. Apr 3;318(7188):921-5.
- Kaplan A, Forbes M, Bonhoure I, Utzet M, Martín M, Manneh M, Ceesay H (2013). Female genital mutilation/cutting in The Gambia: long-term health consequences and complications during delivery and for the newborn. *Int J Women's Health*, 5:323–331.
- Mandara MU (2004). Female genital mutilation in Nigeria. *Int J Gynecol Obstet*, 84:291–298.
- OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Eliminating female genital mutilation: an interagency statement. Geneva: (WHO 2008). 22–7. Available at: http://www.who.int/reproductive_health/publications/fgm/9789241596442/en/index.html. Accessed December 29, 2011.
- Onuh SO, Igberase GO, Umeora OU, Okogbenin SA, Otoide VO, Gharoro EP (2006). Female genital mutilation: Knowledge, attitude and practice among nurses. *J Natl Med Assoc.*;98:409–14.
- Pashaei T, Rahimi A, Ardalan A, Felah A, Majlessi F (2012). Related Factors of Female Genital Mutilation (FGM) in Ravansar (Iran). *J Women's Health Care*, 1(2):1000108.
- Thomas K, Chow K, Kirby RS (2004). Acute urinary retention: a review of the aetiology and management. *Prostate Cancer Prostatic Dis*, 7:32-37
- UNICEF (2013). Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change. New York: UNICEF;.
- UNICEF Innocenti Research Centre (2011). Changing a harmful social convention: female genital mutilation/cutting. New York: UNICEF;2005. Available at: <http://www.unicef-irc.org/publications/396>. Accessed December 26.
- Wadesango N, Rembe S, Chabaya O (2011). Violation of women's rights by harmful traditional practices. *Anthropologist*, 13(2):121–129.
- World Health Organization (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet*, 367:1835–1841.
- Yusuf L, Negash S (2008). Vaginal calculus following severe form of female genital mutilation: a case report. *Ethiop Med J*;46:185–8.