Gynecological complaints and management of women subjected to female genital mutilation

A descriptive study among women attending a university hospital in Norway

Abstract

Background Female genital mutilation (FGM) is a harmful traditional practice comprising procedures involving partial or total removal of external female genitalia and/or narrowing of the vaginal orifice for non-medical reasons. Due to migration pattern, it is estimated to be approximately 17,300 girls and women subjected to FGM currently living in Norway. A number of publications over the last decades have reported long-term health complications after FGM. However, there is a lack of publications on characteristics and quantitative findings in a Norwegian health care setting, especially concerning gynecological impacts of FGM.

The aim of this study was to explore the gynecological complaints, treatment interventions and management of women subjected to FGM in a Norwegian health care setting.

Methods We conducted a retrospective, descriptive study based on medical records of women with FGM who had been in contact with St. Olavs Hospital, University Hospital of Trondheim, Norway, throughout 2004 - 2016. A total of 158 cases were included.

Results Among the 158 women in this study (mean age 26.9, SD = 6.5 years), the majority were from Somalia (n = 96, 60.8%) and Eritrea (n = 32, 20.3%). 125 women (79.1%) presented with FGM type III, 16 (10.1%) with type II and 10 (6.3%) with type I. 69 (55%) women discussed a possible deinfibulation with a gynecologist. At first gynecological examination, FGM was not described for 20% of the women.

Gynecological complaints were described among 119 (75%) women. The most common gynecological complaints were abdominal and pelvic pain (n = 70, 44%), dyspareunia, apareunia (n = 60, 38%) and dysmenorrhea (n = 49, 31%). 86 women (69%) with FGM type III underwent deinfibulation. 20 of the procedures (23%) were performed during vaginal delivery.

Conclusion Our study describes health complaints, treatment interventions and management of women who have been subjected to FGM. We have shown that a substantial part of these women have a high prevalence of gynecological pain conditions, and that this applies to all types of FGM. Healthcare-workers should be aware of these women's need for medical care,

and to a greater extent document their complaints and findings in their contact with women subjected to FGM.

Keywords: Female Genital Mutilation, Circumcision, Infibulation, Gynecological complaints, Deinfibulation, Gynecological examination, Migration

Sammendrag

Bakgrunn Kvinnelig kjønnslemlestelse (KKL) er en skadelig tradisjonell praksis, uten medisinsk indikasjon, og består av delvis eller totalt fjerning av ytre kjønnsorgan og/eller innsnevring av vaginalåpningen. På bakgrunn av migrasjonsmønstre er det estimert å bo 17 300 jenter og kvinner som er kjønnslemlestet i Norge. I løpet av de siste tiårene er det blitt publisert et stort antall artikler som rapporterer om senkomplikasjoner etter kjønnslemlestelse. Likevel er det få publikasjoner som beskriver kvinnene som oppsøker helsehjelp i Norge, deres karakteristika og kvantitative funn, og spesielt gynekologiske komplikasjoner av KKL.

Formålet med studien var å beskrive gynekologiske plager, diagnostikk og behandling blant kvinner med KKL som oppsøkte helsehjelp ved et norsk sykehus.

Metode Vi gjennomførte en retrospektiv deskriptiv studie av journalene til kjønnslemlestede kvinner som hadde vært i kontakt med Kvinneklinikken på St. Olavs Hospital i Trondheim i perioden 01.01.2004 - 31.12.2016.Til sammen ble 158 kvinner inkludert i studien.

Resultater Blant de 158 kvinnene i studien (gjennomsnittlig alder 26.9, SD = 6.5 år), var de fleste fra Somalia (n = 96, 60.8%) og Eritrea (n = 32, 20.3%). 125 kvinner (79.1%) hadde KKL type III, 16 (10.1%) hadde type II og 10 (6.3%) hadde type I. Blant kvinnene med KKL type III, tok 69 (55%) kontakt med lege for å diskutere muligheten for deinfibulasjon (åpning). Ved første registrerte gynekologiske undersøkelse, var 20% av kvinnene ikke beskrevet som kjønnslemlestet.

Gynekologiske plager var beskrevet hos 119 kvinner (75%). De hyppigste gynekologiske plagene var mage- og underlivssmerter (n = 70, 44%), dyspareunia, apareunia (n = 60, 38%) og dysmenoré (n = 49, 31%). Blant kvinner med KKL type III, gjennomgikk 86 (69%) deinfibulasjon. 20 av disse inngrepene (23%) ble utført under fødsel.

Konklusjon Studiet vårt beskriver gynekologiske plager, diagnostikk og behandling av kvinner med kjønnslemlestelse. Vi har vist at en betydelig andel kvinner rapporterer gynekologiske plager i form av underlivssmerter, og at dette gjelder uavhengig av hvilken type KKL de har. Vi håper denne studien vil gjøre helsearbeidere mer bevisst på disse

kvinnenes behov for medisinsk behandling, og at leger i større grad vil dokumentere symptomer og funn ved kontakt med kvinner utsatt for KKL.

Forord

I løpet av det 5. året ved profesjonsstudiet i medisin ved NTNU er det avsatt et semester for å skrive hovedoppgave. Formålet med hovedoppgaven er å få innblikk i medisinsk forskning og å fordype seg i et medisinsk forskningsfelt av interesse, for slik å videreutvikle en vitenskapelig og problemorientert tenkemåte.

Vi har begge hatt et engasjement for global helse i mange år, og gjennom både private og studierelaterte reiser i afrikanske land har vi fått innsikt i ulike kulturer og helsevesen. Og i løpet av medisinstudiet har vi begge utviklet en stor interesse for gynekologi. Vi var derfor raskt ute med å takke ja da vi fikk tilbud om å utføre dette prosjektet sammen med vår veileder Cecilie Hagemann. Studien er en understudie av et nasjonalt prosjekt for å kartlegge kvinner med kjønnslemlestelse i spesialisthelsetjenesten, ledet av gynekolog Sølvi Taraldsen ved Oslo Universitetssykehus.

Vi har innhentet kunnskap og inspirasjon fra Nasjonalt kunnskapssenter for vold og traumatisk stress, som har den nasjonale kompetansefunksjonen mot kjønnslemlestelse i Norge. Blant annet deltok vi på nasjonal fagkonferanse om kjønnslemlestelse høsten 2016.

Gjennom arbeidet med hovedoppgaven har vi hatt tett oppfølging av veilederen vår, og hun har tatt oss med på konsultasjoner og åpningsinngrep hos kvinner utsatt for kjønnslemlestelse. Hennes interesse og engasjement for kvinners helse har gitt oss stor glede og motivasjon i arbeidet,

Selv om kjønnslemlestelse er ulovlig i Norge, har innvandring fra land som praktiserer dette ført til at vi i må forholde oss til denne tradisjonen. Det norske helsevesen har begrenset erfaring med kjønnslemlestelse, og det er derfor behov for økt kunnskap rundt dette temaet. Vi har begge kjent et stort engasjement for temaet. Det har føltes meningsfylt å kunne bidra til å øke kompetansen rundt dette fagfeltet, da vi håper det vil kunne bidra til et bedre helsetilbud til kvinner som er kjønnslemlestet.

Vi presenterer hovedoppgaven som et utgangspunkt for en artikkel, og er motiverte for å jobbe mot en fremtidig publisering i medisinsk tidsskrift.

Vi ønsker å takke vår veileder, førsteamanuensis Cecilie Therese Hagemann, for god støtte gjennom hele prosjektet. Din tålmodighet og oppmuntrende væremåte har betydd mye for oss. Vi vil også takke vår biveileder Risa Lonnee-Hoffmann for konstruktive og gode tilbakemeldinger i utforming av oppgaven. Til slutt vil vi takke hverandre for godt samarbeid og et unikt vennskap.

Trondheim, 16.mai 2017

Tone Aalberg Andersen og Silje Tvenge

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Abbreviations

CRF Case Report Form

FGM Female Genital Mutilation

ICD International Classification of Diseases

KKL Kvinnelig kjønnslemlestelse

NTNU Norwegian University of Science and Technology

REK Regional Committee for Medical and Health Research Ethics

WHO World Health Organization

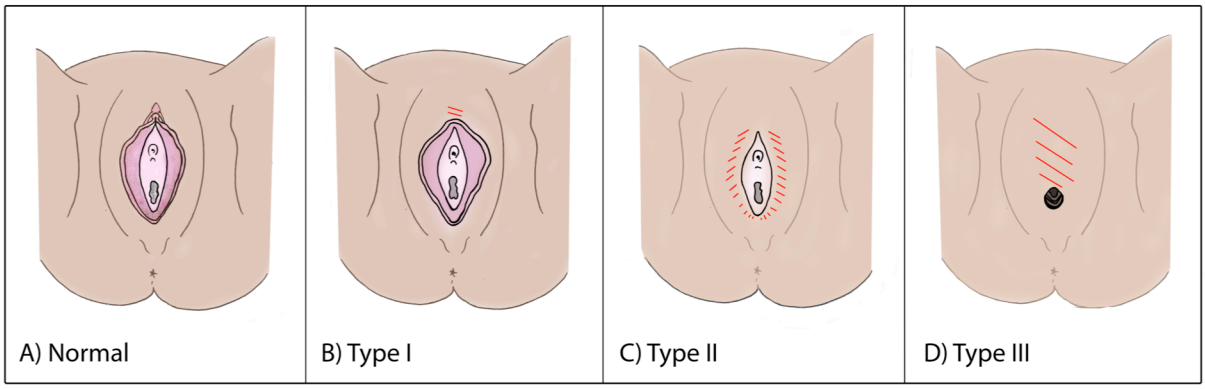
Introduction

Worldwide it is estimated that 133 millions girls and women in 29 countries have been subjected to female genital mutilation (FGM). Immigration from countries where FGM is prevalent has made FGM a global concern, and there is a need for increased knowledge about FGM in order to provide good healthcare for women who have been affected. There is no tradition for practicing FGM in Norway. However, approximately 17,300 girls and women living in Norway are estimated to have been subjected to FGM prior to immigration. (1)

In 2004, specialized gynecological outpatient clinics were established in all health regions of Norway, with an aim to improve medical care for women subjected to FGM. One such clinic was established at St. Olavs Hospital, and all health care professionals in the region of Central Norway (Helse-Midt) were encouraged to refer affected women there.

FGM is a harmful traditional practice comprising procedures involving partial or total removal of external female genitalia and/or narrowing of the vaginal orifice for non-medical reasons. The World Health Organization (WHO) defines four types of FGM, according to the extent of the procedure (2):

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV: All other harmful procedures to the female genitalia for nonmedical purposes, e.g. pricking, piercing, incising, scraping and cauterizing



Figur 1 Illustration of normal female genitalia and female genital mutilation types I – III. From left: normal external female genitalia, type I (clitoridectomy), type II (excision) and type III (infibulation)

The most extensive form is FGM type III. Due to the migration patterns, this is the most prevalent type of FGM in Norway (1, 3). FGM can lead to long-term physical and psychological health consequences, particularly its extensive forms (2).

A large number of publications over the last decades have reported long-term health complications after FGM. There seems to be a trend for women with FGM to be more likely to experience menstrual problems, pain during intercourse and urination, vaginal itching and discharge, as well as vaginal and urinary tract infections (4, 5).

Several studies on FGM have been conducted in Scandinavia. The majority of these have a sociocultural perspective (6-11), and a few papers estimate the prevalence of FGM in Scandinavian countries (1, 12, 13). Concerning medical health outcomes, only a handful of articles have been published in Norway. Among these are review articles and a paper addressing perinatal complications of FGM (5, 14, 15). However, there is a lack of publications describing characteristics and quantitative findings in a Norwegian health care setting, especially concerning gynecological impacts of FGM. There is a considerable public attention and awareness of this medical topic, and more in-depth study is needed to attain more accurate statistics and knowledge (16).

A recent paper identified thematic areas of significant evidence gaps and controversy regarding current clinical management of FGM (17). Among these areas were deinfibulation outside of pregnancy and clitoral reconstruction, in addition to training, skills, and confidence

among healthcare providers. Providers currently lack awareness on the prevalence, diagnosis and management of FGM (18). In addition, challenges exist in identifying and categorizing FGM according to the WHO classification (19).

Through this study we contribute to the knowledge about genitally mutilated women living in Western countries. Our aim is to explore the gynecological complaints, treatment interventions and management of women subjected to FGM at St.Olavs Hospital.

Material and Methods

Design and sample

We conducted a retrospective, descriptive study based on the records of women with FGM who attended the outpatient clinics or the ward at the Department of Gynecology and Obstetrics at St. Olavs Hospital, Trondheim, during the period from 01.01.2004 – 31.12.2016. Patients were identified in the St.Olavs Hospital's medical record systems; Doculive and Natus. In some cases, medical records from other hospitals in the region Helse Midt[1] were available from the St.Olavs medical record systems, and these were used to supplement our data. We identified women subjected to FGM by performing a search on codes from the International Classification of Diseases (ICD). Since ICD did not have a code for FGM until the middle of year 2016, we used the following codes to identify eligible cases:

ICD-codes for search:

Z90.7	Acquired absence of genital organ(s)
S38.2	Traumatic amputation of external genital organs
N90.7	Vulvar cyst
O34.7	Maternal care for abnormality of vulva and perineum
O66.8	Other specified obstructed labour
R30.0	Dysuria
T91.8	Sequelae of other specified injuries of neck and trunk

NCSP-codes for procedures:

LFE 10	Plastic repair of vulva
LFE 96	Other repair of vulva or perineum

To be included in the study a description of FGM some place in the medical record was required. Altogether, 161 women were identified from whom medical data were collected during the study period. Duplicate registrations (n= 3) were excluded, leaving a total of 158 women eligible for the study.

[1] Central Norway Regional Health Authority

Data collection and storage

The key identifying patients in the study, i.e., personal id number and study number, was stored locally at our main supervisor's separate disc area for research matters, in the St.Olavs Hospital secure data system. Information was extracted from the women´s records and registered directly in an electronic web-based data collection system, that means a case report form (CRF), developed and administered by the Unit of Applied Clinical Research at the Norwegian University of Science and Technology (NTNU) (Appendix 1). Through this system, all information was encrypted and de-identified.

Variables

When using the word deinfibulation, we refer to the procedure of *medical* deinfibulation unless otherwise stated.

Characteristics of the women included were based on information from the first doctor´s appointment concerning FGM, from here on referred to as the first doctor's appointment. We included age, origin, living situation, occupational status, highest completed educational level and time of residence in Norway. Time of residence was categorized as *newly arrived* if the woman arrived in Norway less than one year ago, else as *came as a child* or *as an adult* depending of age (under or over 18 years old).

We created three language categories: "Norwegian", meaning the women could speak Norwegian; "Communicable language", meaning she could communicate with the physician in language other than Norwegian; "Other non-communicable language" meaning the women and the physician could not communicate in any language.

The women's type of FGM was categorized according to WHO's classification of FGM (see the introduction section) (2). In cases where the physician's classification of FGM did not match their description of external genitalia, we chose to use the physician's description and re-classify their type of FGM according to WHO classifications.

The clitoris was described as either present, partially or totally removed. If the medical record stated that the clitoris was not palpable, it was considered as totally removed.

The seal of skin created by the infibulation procedure, or as a consequence of labia minora or majora adherence after the cutting, are referred to as skin seal.

Study approval

The study was approved by the Regional Committee for Medical and Health Research Ethics (REK-Midt), REK reference number 2015/433.

Statistical analyses

Descriptive characteristics were reported by frequencies and proportions for the categorical variables. Data analysis was performed by using IBM SPSS Statistics. Associations between gynecological complaints and type of FGM were tested by using the Fisher´s Exact Test.

Results

Table 1 summarizes the characteristics of the 158 women included in this study. The mean age was 26.9 (SD = 6.5 years), ranging from 13 to 48 years old. At time of first doctor´s appointment, 52 women (33%) were students and 24 (15%) were refugees. Only 20 women (13%) had paid work. According to the medical records, 26 women (16.5%) had completed primary- or high school, whilst only 5 (3.2%) had completed higher education. To a large extent, information about highest completed educational level was missing/not available. As many as 86 women (54%) came to Norway as adults, and 29 (18%) had arrived less than 12 months ago.

Table 2 summarizes information about referral of the 158 women in this study. 90 women (78%) were referred to St. Olavs Hospital from primary health care services, most of them from a general practitioner (n = 48, 41%) or midwife (n = 38, 33%). Only in 41 cases (35%) the referring health practitioner had performed an inspection of the genitals. The physician was informed about the women´s FGM via the referral in 103 cases (65%).

Table 1 *Background characteristics among 158 women with FGM who had been in contact with St. Olavs Hospital in Trondheim, Norway, throughout 2004 - 2016.*

Characteristics	N = 158 (%)
Origin	
Somalia	96 (60.8)
Eritrea	32 (20.3)
Ethiopia	11 (7.0)
Sudan	7 (4.4)
Other countries[2]	12 (7.7)
Relationship status	
Married	67 (42.4)
In a relationship/cohabitant	35 (22.2)
Single	29 (18.4)
Divorced/separated/widow	4 (2.5)
Information missing	23 (14.6)
Occupational status	
Employed	20 (12.7)
Under education	52 (33.0)
Refugee	24 (15.2)
Unemployed	8 (5.1)
Information missing	54 (34.2)
Time of residence in Norway	
Newly arrived (< 1 year)	29 (18.4)
Came as child (< 18 years)	29 (18.4)
Came as adult > 18 years)	86 (54.4)
Information missing	14 (8.9)

[2] Other countries = Sierra Leone, Gambia, Kenya, Iraq, Guinea, Kurdistan, Nigeria og Ghana.

Table 2 *Information about referral among 158 women with FGM who had been in contact with St. Olavs University Hospital in Trondheim, Norway, throughout 2004 - 2016.*

Characteristics	N (%)
Referral, n = 158	
Referral concerning FGM	116 (73.4)
Contact concerning FGM, without any referral	11 (7.0)
Authority referring, n = 116	
Primary health care service	90 (77.6)
Specialized health care service	21 (18.1)
Information missing	5 (4.3)
Profession of authority referring, n = 116	
General practitioner	48 (41.4)
Midwife	38 (32.8)
Gynecologist	14 (12.1)
Other	9 (7.7)
Information missing	7 (6.0)
Inspection of genitalia by authority referring, n = 116	
Yes	41 (35.3)
No	12 (10.3)
Information missing	63 (54.3)
Information about FGM to the physician, n = 158	
Described in the referral	103 (65.2)
Verbal information from patient	19 (12.0)
During gynecological examination	18 (11.4)
Information missing	18 (11.4)

The majority of the women (n = 79, 50.0%) could not speak Norwegian and were not able to communicate with the physician in another language. Among these, 59 women (74.7%) were communicating through a professional interpreter, whilst a few (n = 7, 8.8%) had a family member, partner or friend with them to translate. In 13 (16.5%) cases there was no information about anyone translating. The rest of the women could speak Norwegian (n = 56, 35.4%) or were able to communicate with the physician through another language (n = 7, 4.4%).

On average the women had two consultations regarding FGM (ranging from one to nine). 16 women (10.1%) had at some point cancelled their appointment. The women had several reasons to seek out for a physician to evaluate their FGM, and for some it was due to more than one reason. The causes of contact were due to pregnancy for 89 women (56.3%), and for 86 women (54.4%), it was due to gynecological complaints. For 69 women (43.7%) it was to discuss a possible deinfibulation. Some (n = 14, 8.9%) were newly married or in a new relationship, and 4 women (2.5%) were consulting the physician due to uncertainty about being subjected to FGM. Only looking at the women interested in deinfibulation, nearly half of the women (n = 30, 43.5%) were pregnant, and 13 women (18.8%) were newly engaged in marriage or started a new relationship.

In our study 90 women (57.0%) had undergone genital mutilation before the age of 13, at a mean age of 7.4 years old. The youngest was just a few days old; the oldest was 15 years at the time of FGM. For 25 women (20.0%) with FGM type III, a former opening of the infibulation had been conducted. The reason for this was mainly childbirth (n = 19, 15.2%), and 10 women (40.0%) had been reinfibulated. To a large extent this information was missing.

91 women (57.6%) were pregnant at their first doctor’s appointment. Among these, 88 women had documented the gestational age in the medical record. Mean gestation age was 26.4 weeks (SD = 9.3), ranging from 4 to 42 weeks. The distribution of gestational age among the pregnant women subjected to FGM is shown in Figure 2.

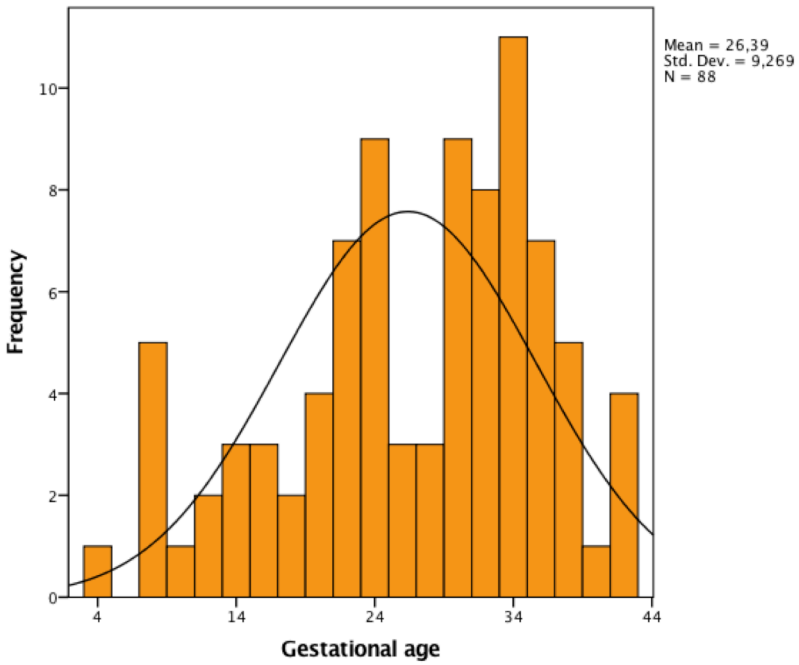


Figure 2 The distribution of gestational age among the 88 pregnant women subjected to FGM who had been in contact with St.Olavs Hospital in Trondheim, Norway, throughout 2004 – 2016.

66 women (41.8%) had been pregnant prior to their first doctor's appointment concerning FGM, of whom 43 (64.0%) had experienced live births. A few (n = 6, 9.1%) had experienced one or more stillbirths and the rest had undergone miscarriages or elective abortions. Additional information about gynecological history is shown in Table 3.

For most of the women (n = 99, 62.7%), information about where the FGM took place was missing. For 59 women (37.3%), the FGM took place in the country of origin. Furthermore, information about who performed the FGM was missing in 139 cases (88%). Only 16 women (10.1%) reported to have been genitally mutilated by a traditional circumciser, whilst 3 women (1.9%) had it done by a health practitioner.

Table 3 Gynecological history among 158 women with FGM who had been in contact with St. Olavs University Hospital in Trondheim, Norway, throughout 2004 - 2016.

Characteristics	N = 158 (%)
Age at the time of genital mutilation	
Child (< 13 years)	90 (57.0)
Teenager (13-18 years)	6 (3.8)
Information missing	62 (39.2)
Sexual debut	
Yes	132 (83.5)
No	17 (10.8)
Information missing	9 (5.7)
Pregnant at first doctor's appointment	
Yes	91 (57.6)
No	64 (40.5)
Unknown	3 (1.9)
Number of previous pregnancies	
1	32 (20.3)
2	13 (8.2)
≥ 3	20 (12.6)

Table 4 shows the detailed description of the women´s external genitalia given in the medical records. At first gynecological examination, FGM was not described in 31 cases (19.6%). 125 women (79.1%) presented with FGM type III, 16 (10.1%) with FGM type II and 10 (6.3%) with FGM type I.

A skin seal was described as covering parts of, or the entire vaginal opening in 64 cases (40.5%), and as covering the front of vulva, including the urethra, in 23 (14.4%) cases. For 30 women (19.0%) the urethral opening was described as not visible, and for 10 women (6.4%) there were descriptions of fistulas or openings in the skin seal.

Only for 61 women (38.6%) the size of vaginal opening was described. For 32 women (20.2%), it was described as less than 2 cm or open for one or no fingers, while for 29 (18.4%) as 2-3 cm or open for two fingers.

For 12 women (7.6%), the external genitalia were not described. 17 (10.8%) of the gynecological examinations were perceived as painful and/or causing mental distress for the patient. In the remaining cases information about these issues was missing.

Table 4 Detailed description of external genitalia[3] among 158 women with FGM who had been in contact with St. Olavs University Hospital in Trondheim, Norway, throughout 2004 - 2016.

Characteristics	**Total N = 158 (%)**	**FGM type I/II 26 (17.2) n *(%)***	**FGM type III 125 (82.8) *n (%)***
Clitoris intact	8 (5.1)	0	7 (5.6)
Clitoris partially removed, but palpable	68 (43.0)	17 (65.4)	51 (40.8)
Clitoris totally removed, not palpable	29 (18.4)	2 (7.7)	27 (21.6)
Clitoris not described	53 (33.5)	7 (26.9)	40 (32.0)
Labia minora present	7 (4.4)	4 (15.4)	3 (2.4)
Labia minora partially removed	32 (20.3)	6 (23.1)	26 (20.8)
Labia minora totally removed	50 (31.6)	9 (34.6)	41 (32.8)
Labia minora not described	27 (17.1)	3 (11.5)	24 (19.2)
Labia majora partially or totally removed	5 (3.2)	0	5 (4.0)
Scarring and/ or keloid	13 (8.2)	2 (7.7)	11 (8.8)
Perineum is not described	69 (43.7)	6 (23.1)	62 (49.6)
Other description of the external genitalia[4]	72 (45.6)	6 (23.1)	65 (52.0)

[3] More than one category possible

[4] Other description = asymmetry, stricture under the seal, nevne flere eksempler her

Gynecological complaints were described among 119 (75.3%) women. The most common were abdominal and pelvic pain (44%), dyspareunia/apareunia (38%), and dysmenorrhea (31%). Table 5 shows detailed information about the complaints.

Table 5 Gynecological complaints[5] among 158 women with FGM who had been in contact with St. Olavs University Hospital in Trondheim, Norway, throughout 2004 - 2016.

Characteristics	**Total N = 158 (%)**	**FGM type III 125 (82.8) n (%)**	**FGM type I/II 26 (17.2) n (%)**	**P-value**
Abdominal/pelvic pain	70 (44.3)	53 (42.4)	15 (57.7)	0.19
Dyspareunia/apareunia	60 (38.0)	53 (42.4)	7 (26.9)	0.18
Dysmenorrhea[6]	49 (31.0)	42 (33.6)	6 (23.1)	0.35
Painful/Protracted urination	29 (18.4)	21 (16.8)	7 (26.9)	0.26
Symptoms of infection in vulva/vagina[7]	27 (17.1)	21 (16.8)	6 (23.1)	0.41
Recurrent urinary tract infection	6 (3.8)	6 (4.8)	0	0.59
Cyst formation	1 (0.6)	1 (0.8)	0	1.0
Other complaints	22 (13.9)	18 (14.4)	3 (11.5)	1.0

Table 6 shows information about treatment of the 158 women. Among women with FGM type III, 86 (69%) underwent a deinfibulation procedure. 20 (23%) of these procedures were performed during vaginal delivery. There were descriptions of deinfibulation performed in extent to the urethral opening for 54 women (62.8%), and further ahead or to the clitorial area for 14 (16.3%) women. Two gynecologists mainly performed the procedure. In most cases, the procedure was done by either using local as only anesthetic, or local in addition to general anesthesia for the purpose of reducing postoperative pain. Only two of the women (1.3%) complained about pain during the surgical procedure, and we did not find any information about possible emotional reactions during or after the procedure. Information about contact with the hospital in the aftermath of surgery was found in 27 cases (32.9%). 12 women (13.5%) had a check-up, one of them via telephone. The cause of contact was due to

[5] More than one category possible
[6] Included obstructed menstruation
[7] Itching, vaginal discharge, infection in vulva/vagina

complications[8] for 4 women (14.8%), one woman was asking for advice, and 22 women (81.5%) were in contact with the hospital for other reasons.

Table 6 *Treatment among 158 women with FGM who had been in contact with St. Olavs University Hospital in Trondheim, Norway, throughout 2004 - 2016.*

Characteristics	N (%)
Indication for surgical treatment, n = 158	
Yes	98 (62.0)
No	50 (31.6)
Other	6 (3.8)
Not considered	4 (2.5)
Deinfibulation among women with FGM type III, n = 125	
Yes	66 (52.8)
Yes, during labour	20 (16.0)
No[9]	7 (5.6)
Missing	32 (25.6)
Anesthesia, n = 86	
Local as the only anesthesia	28 (32.6)
Spinal	17 (19.7)
General	31 (36.0)
Other[10]	1 (1.2)
Unknown	9 (10.5)

[8] Complications = one had retention of urine and three had vulvar pain

[9] No includes patients who was already deinfibulated or for other reasons did not want to be deinfibulated

[10] Other = Epidural during vaginal delivery

Key findings

- The majority of the women were from Somalia (61%) and Eritrea (20%)
- At first gynecological examination, FGM was not described in 20% of the cases
- FGM type III was present in 125 cases (79%)
- 69 women (44%) were in contact with a physician to discuss a possible deinfibulation
- Gynecological complaints were described among 119 women (75%)
- The most common gynecological complaints were abdominal and pelvic pain (n = 70, 44%), dyspareunia and apareunia (n = 60, 38%) and dysmenorrhea (n = 49, 31%)
- 86 women (69%) with FGM type III underwent deinfibulation, of whom 20 women had the procedure performed during vaginal delivery

Discussion

To summarize the findings among the 158 women in this study, the mean age was 27 years, and most women originated from Somalia and Eritrea. The majority of the women presented with FGM type III, followed by type II and type I. At first gynecological examination at the hospital there was no description of the FGM in 20% of the medical records.

Gynecological complaints were described among three out of four women. The most common gynecological complaints were pain conditions like dyspareunia, dysmenorrhea, and abdominal and pelvic pain. About 70% of women with FGM type III underwent deinfibulation, and 23% of the deinfibulation procedures were performed during vaginal delivery.

Regarding the high number of women in this study originating from Somalia and Eritrea, the findings are consistent with the migration patterns to Norway (1). Furthermore, 70% of the women had been in Norway for more than a year before seeking medical help for their FGM. Considering the extent of health problems that may be present among refugees and asylum seekers, it could be that issues concerning FGM are postponed. But it could also be due to a lack of information about the health care opportunities in a new country.

Most of the women in our study could not speak Norwegian. Among them, three out of four were communicating through a professional interpreter, whilst nearly 10% had a family member, partner or friend to translate for them. Having a private relationship with the interpreter may cause insufficient or incorrect information passing between the physician and the patient. This also applies if the interpreter is male, as the gender of the interpreter may be important in the interaction for women with FGM (20). Furthermore, it is well documented that there are linguistic and ethical challenges pertaining to the use of untrained interpreters. Linguistic difficulties may occur due to lack of language ability, which can also be affected by stress, and knowledge of medical terminology. Ethical problems include issues with confidentiality and privacy, as well as difficulty in discussing sensitive issues as e.g. FGM (21).

Family members as interpreters often feel their role is to facilitate understanding rather than to render exactly what is said, which may result in key information being omitted (22). Some might negotiate the treatment directly with the physician, speaking on behalf of the relative, and may also have their own agenda (20). Professional interpreters, on the other hand, fulfill the needs of neutrality and accuracy. It is therefore believed that the use of professional interpreters is the preferable option, resulting in improved care and greater patient satisfaction (23).

For 20% of the included women, the external genitalia were not described with FGM at the time of first gynecological examination. This is surprising considering that the most common type of FGM was the most extensive WHO type III, i.e. infibulation, which obviously should be the most recognizable type. Hence, results from this study indicate that opportunities to recognize FGM are frequently missed by the doctors at St. Olavs Hospital.

There might be several reasons for why physicians fail to recognize FGM. Discussing FGM with patients is a sensitive matter, and may make health care workers feel uncomfortable. This could be due to embarrassment, uncertainty about how to frame the questions, or anxiety about being perceived as culturally insensitive (24). Norwegian health care workers have described dealing with infibulated women as both emotionally and ethically difficult, and they may see the skin seal as the symbol of an oppressed person (25). Other studies, too, have observed similar results with missed opportunities for diagnosing FGM. These studies highlight that lack of training in FGM both during medical school, and during residency in gynecology and obstetrics, could make junior doctors unfamiliar with FGM (19). Furthermore, the WHO classification may not be easily memorized and applied in practice (19). Discussing FGM with affected women can make a huge difference to the patient's health and wellbeing. It could be highly relevant to their clinical situation, and once FGM is identified, physicians can offer the support and treatment needed (26).

We found several types of long-term gynecological problems among the women in this study. The most common complaints were dyspareunia, dysmenorrhea, and pelvic and abdominal pain. Urinary problems like painful and protracted urination were also frequent. This is in contrast to the findings in a meta-analysis, in which the most common complications associated with FGM were urinary tract infections, bacterial vaginosis and dyspareunia. The meta-analysis also revealed that the most frequently measured consequences were genital

tissue damage, vaginal discharge, itching, urological complications and infections (5). The different findings could be due to differences between topics addressed by the general practitioner and the hospital, in which our findings are from the medical record at the hospital. We must also point out that 11% of the women in our study had never had sexual intercourse, and thus would not report dyspareunia. Still, dyspareunia is still the most frequently reported complaint in our study.

We compared the frequency of gynecological complaints among women with FGM type I/II to type III, but we did not find any significant association between the FGM type and complaints. This may indicate that women with a lesser degree of FGM may have more complaints than we have been aware of. In particular women subjected to cutting of the clitoridal area could have more vulvar pain or feel less sexual desire compared to those with FGM type III who in some cases have preserved a rather large part, and sometimes all, of the clitoridal area. The possibility or willingness to talk about intimate and sexual problems and the time passed since immigration to Norway may bias our results of FGM type I coming out as equally bad for gynecological health as the more extensive FGM conditions. Unlike our findings, reports from Eritrea indicate a lower risk of sexual problems with FGM type I-II compared to type III (27, 28). However, due to small study samples from women with FGM type I and II, we can not draw any firm conclusions. Since there are few studies on this topic, there is a need for further research on how the varying degrees of FGM are associated with the different complaints and pain conditions (14, 29).

Our results shows that about two thirds of the women with FGM type III underwent a deinfibulation procedure, and for 20% of the women a former opening of the infibulation had already been conducted. The Norwegian guidelines for health care and management of women subjected to FGM, recommends that all women subjected to FGM type III should be offered deinfibulation, regardless of any health complaints (30). Furthermore, it is recommended to perform deinfibulation as a planned procedure before pregnancy or during the second trimester of pregnancy, rather than as an emergency procedure during vaginal delivery. The reason for this is partly because Norwegian healthcare workers still have limited experience of dealing with women with FGM type III. (31)

In spite of these recommendations, 23% of the deinfibulation procedures at St. Olavs Hospital were performed during vaginal delivery. From the medical records we found that

some of these women were offered the procedure earlier in pregnancy, but preferred to be deinfibulated during second stage of delivery, in order to avoid another painful procedure. This is similar to a report from a British study (4). Here, the authors described that some pregnant women considered vaginal delivery as the only indication for deinfibulation, and therefore wanted to avoid a "futile" deinfibulation in case of an acute cesarean section.

There may be many reasons to request a deinfibulation procedure. Among the women interested in deinfibulation, just above half were pregnant and about 20% of them were newly engaged in marriage or had started a new relationship. Traditionally there are only two legitimate reasons for infibulated women to request an opening procedure: marriage and childbirth. Deinfibulation of single women are for some viewed with skepticism, and premarital deinfibulation is only accepted in case of severe health complications (7). Women with FGM not following these rules could be afraid of losing their virginity and be subjected to social stigma. Due to this, it is not surprising that previous studies have found the primary reasons to request deinfibulation to be pregnancy, childbirth and marriage (4, 7, 32). Nevertheless, dysmenorrhea, apareunia and dyspareunia also prove to be important reasons to request the procedure, which appears consistent with our findings of the most common gynecological complaints among women with FGM contacting St. Olavs Hospital (32).

Pain and psychological reactions were not described in the majority of the medical records. One reason for this may be that gynecological examination and medical deinfibulation does not cause pain or psychological distress for patients with FGM. This is rather unlikely, and no documentation does not rule out the existence of such problems, and may indicate a lacking focus on mental health.

Studies have shown that women with FGM may be more likely than women without FGM to have a psychiatric diagnosis, and to a greater extent suffer from anxiety, somatization, phobia and re-experiences of being cut as girls (14, 33). As such, the procedure of a gynecological examination or deinfibulation could lead to re-experiences causing secondary traumatization. In countries where FGM is practiced the procedure is widespread and culturally embedded, which could be a protective factor against psychological stress(14). In a Norwegian setting, on the other hand, these protective factors may be missing. Hence, there is a need for further studies on the psychological implication of FGM in a Western setting.

In line with the guidelines from Norwegian Medical Association, St.Olavs Hospital does not hold routinely postoperative control after deinfibulation procedures (30). Another plausible reason for the lack of information about psychological reactions could therefore be that it does not reach physicians in secondary health care services, and hence is not written in the hospital´s medical records.

While looking through the medical records we also found that just a few women had descriptions of how the genital mutilation occurred. Their age at time of FGM, where and who performed the procedure, and whether the women had been reinfibulated were to a great extent missing. By asking about these matters, physician may receive important information about the women's health (4). Also, through health educational work, physicians have a unique opportunity to influence knowledge and attitudes towards FGM. By addressing issues related to FGM, the affected women are forced to make an assessment of their own position and attitude regarding the procedure. As a consequence, the physician indirectly may contribute to prevent new daughters and nieces of being exposed to FGM.

Strength and limitations

This study has several limitations. It is important to note that this is a study of medical records of women with FGM, only including women who have been in contact with St. Olavs Hospital. It is therefore reasonable to assume that, to some extent, women not experiencing any health issues are automatically excluded, leading to a selection bias.

As this study is retrospective, the information about women with FGM is not standardized. This also results in a high proportion of missing information regarding certain topics. In addition, some subgroups are too small to make a meaningful comparison between groups. As our source of information was medical records, the reliability of the data is influenced by the information given by the women and the accuracy of the physicians´ descriptions. Before 2016, no diagnostic code existed. Therefore, the study might have failed to identify all women with FGM contacting St. Olavs Hospital during this study period.

Despite the above-mentioned limitations, this explorative study has contributed to filling a gap of knowledge about gynecological consequences of FGM in a Nordic setting. It is a strength to our study that our cases were unselected. We have included all patients with descriptions compatible with FGM, and not only those referred with a related problem. The long study period contributed to us gathering a rather large sample size otherwise not possible. Furthermore, by including women with FGM type I and II we got a perspective of these women´s gynecological complaints which rarely are documented in Nordic literature since the most obvious and anatomical changes and more easily accessible findings are from infibulated women.

Conclusion

Female genital mutilation can lead to long-term physical and psychological health consequences (2). Our study provides descriptive data regarding gynecological health complaints, treatment interventions and management of women who have been subjected to FGM in a Norwegian setting. We have shown that a substantial part of these women have a high prevalence of gynecological pain conditions, and that this applies to all types of FGM. Our study contributes to the knowledge on how Norwegian medical doctors acknowledge and treats women with FGM, which so far has been only limitedly described.

By inquiring about genital mutilation when meeting women from high-risk countries, health care professionals can contribute to prevention and treatment of associated psychiatric and medical conditions. In addition, through health educational work, doctors have a unique opportunity to influence knowledge and attitudes towards FGM.

As there are few available studies on the gynecological outcomes of FGM in a Nordic setting, more research is still required to improve the health care service for these women. We hope this study will make health care-workers conscious of these women's need of medical care, and that physicians to a greater extent report on these issues in their contact with women subjected to FGM.

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Appendix 1

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Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Polikl. beh. av kvinner med kjønnslemlestelse

Silje Tvenge
St. Olavs Hospital (400)

Participant No: 162 **Inclusion date:** 02/05/2017 Another participant

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Henvisningsgrunn arsak til kontakt
Anamnese og aktuelt
Status og funn
Behandling

Bakgrunnsoppl administrative opplysn

1. Årstall for første besøk
   - ○ 2004
   - ○ 2005
   - ○ 2006
   - ○ 2007
   - ○ 2008
   - ○ 2009
   - ○ 2010
   - ○ 2011
   - ○ 2012
   - ○ 2013
   - ○ 2014
   - ○ 2015
   - ○ 2016
2. Alder ved konsultasjonen
3. Sivil status
   - ○ Gift
   - ○ Samboer
   - ○ I forhold
   - ○ Ugift/enslig
   - ○ Skilt/separert/enke
   - ○ Opplysninger mangler
4. Fødeland
   - ○ Somalia
   - ○ Eritrea
   - ○ Etiopia
   - ○ Sudan
   - ○ Gambia
   - ○ Annet land
5. Hvis annet land, hvilket?
6. Botid i Norge
   - ○ Nylig kommet til Norge
   - ○ Kom til Norge som barn
   - ○ Kom som voksen, er ikke nyankommet
   - ○ Født i Norge
   - ○ Opplysninger mangler

   Oppholdstid i mnd/år opplyst i journal besvares i eget spørsmål under
7. Stilling (hovedaktivitet)
   - ○ Under utdanning
   - ○ Yrkesaktiv
   - ○ Ikke yrkesaktiv
   - ○ Asylsøker
   - ○ I introduksjonsprogrammet
   - ○ Papirløs
   - ○ Annen
   - ○ Ikke opplyst
8. Hvis annen stilling, hvilken?

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Registrering av omskjering

1. Dato for første gang det er gitt en diagnosekode (dd.mm.åååå)

2. Hvilke av diagnosesøkskodene er benyttet?
   - ☐ Tap av kjønnsor
   - ☐ Traumatisk amputasjon av ytre kjønnsorgan
   - ☐ Omsorg av og behandling av mor med patologisk tilstand i ytre kvinnelig kjønnsorgan og perineum
   - ☐ Følgetilstand etter andre spesifiserte skader på hals og trunkus
   - ☐ Annen spesifisert mekanisk hindret fødsel
   - ☐ Annen rekonstruktivt inngrep vulva (de-infibulering)
   - ☐ Vulva kirurgi (vulvaplastikk)
   - ☐ Cyste i ytre kvinnelige kjønnsorgan

3. Andre relevante diagnosekoder

Max 255 characters. remaining.

4. Dato for første gang omskjæring er beskrevet i journalen? (dd.mm.åååå)

5. Informasjon fra
   - ☐ Oppgitt muntlig fra pasient
   - ☐ I forbindelse med gynekologisk undersøkelse
   - ☐ Oppgitt i henvisningen
   - ☐ Ikke oppgitt

6. Dato for første gynekologiske undersøkelse (dd.mm.åååå)

Andre opplysninger / Additional Information or Corrections

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9. Utdanning, høyeste fullførte

- ○ Grunnskole
- ○ Videregående
- ○ Høyere utdanning
- ○ Ikke opplyst

Andre opplysninger / Additional Information or Corrections

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Henvisning og tid for konsultasjon

1. Henvisning
   - ○ Ja
   - ○ Nei, tatt kontakt uten henvisning
   - ○ Annet
2. Hvis annet, hva?
3. Hvis ja, henvist fra
   - ○ Primærhelsetjenesten
   - ○ Samme sykehus
   - ○ Annet sykehus eller praktiserende spesialist
   - ○ Barnevernet
   - ○ Politiet
   - ○ Annet
   - ○ Uopplyst
4. Hvis annet, hva?
5. Yrkesgruppe som henviser
   - ○ Jordmor
   - ○ Helsesøster
   - ○ Barnelege
   - ○ Gynekolog
   - ○ Annet
   - ○ Uopplyst
6. Hvis annet, hva?
7. Dato for henvisning (dd.mm.åååå)
8. Dato for første besøk i forbindelse med omskjæring (dd.mm.åååå)
9. Dato for ferdig behandlet (dd.mm.åååå)

   Her menes dato for deinfibulasjon eller siste kontakt
10. Hvor mange konsultasjoner var hun til? (antall besøk i forbindelse med omskjæring)

    Save
11. Har pasienten avbestilt/endret timer eller ikke møtt?
    - ○ Ja
    - ○ Ikke opplysninger
12. Hvis ja, antall ganger
    - ○ 1
    - ○ 2
    - ○ 3
    - ○ 4
    - ○ 5 eller mer
13. Er det beskrevet at kvinnen er omskjært i henvisningen?
    - ○ Ja
    - ○ Nei
14. Har henviser utført inspeksjon av ytre kjønnsorgan?
    - ○ Ja
    - ○ Nei

Ikke opplyst

Andre opplysninger / Additional Information or Corrections

Lagre svar / Save and view log | Tilbakestill skjema / Reset

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Polikl. beh. av kvinner med kjønnslemlestelse

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Henvisningsgrunn arsak til kontakt

Oppgi alle aktuelle.

1. Er omskjæring årsaken til at pasienten tar kontakt?
   - ○ Ja
   - ○ Nei, omskjæring blir kun nevnt ifm annen kontaktårsak
2. Er omskjæringen blitt vurdert av helsepersonell?
   - ○ Ja
   - ○ Nei
3. Pas ønsker åpning
   - ○ Ja
   - ○ Nei
   - ○ Ikke aktuelt
   - ○ Ikke opplyst
4. Skal gifte seg/har fått kjæreste
   - ○ Ja
   - ○ Nei
   - ○ Uopplyst
5. Graviditet
   - ○ Ja
   - ○ Nei
6. Undersøke om hun er omskåret
   - ○ Ja
   - ○ Nei
7. Vurdere kjent omskjæring
   - ○ Ja
   - ○ Nei
8. Gynekologiske plager ved første konsultasjon angående omskjæring
   - ○ Ja
   - ○ Nei
   - ○ Ikke opplyst
9. Vannlatingsplager
   - ○ Ja
   - ○ Nei
10. Smerter i underlivet
    - ○ Ja
    - ○ Nei

    Save
11. Smerter i mangen?
    - ○ Ja
    - ○ Nei
12. Smerter ved menstruasjon?
    - ○ Ja
    - ○ Nei
13. Dyspareuni (samleiesmerter)
    - ○ Ja
    - ○ Nei
14. Andre gynekologiske plager

    Max 255 characters. remaining.

15. Opplysninger om henvisningsårsak/årsak til kontakt mangler

- ○ Ja
- ○ Nei

Andre opplysninger / Additional Information or Corrections

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Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Polikl. beh. av kvinner med kjønnslemlestelse

Silje Tvenge
St. Olavs Hospital (400)

Participant No: 162 **Inclusion date:** 02/05/2017 Another participant

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Anamnese og aktuelt

1. Snakket kvinnen norsk?
   - ○ Hun snakket norsk
   - ○ Hun snakket ikke norsk, men kunne gjøre seg forstått på annet språk uten bruk av tolk.
   - ○ Hun snakket ikke norsk
   - ○ Uopplyst

   Hvis hun hadde bodd lenge i Norge og språk ikke er nevnt, vurder om det fremstår ut fra journalen som at språk ikke var en problemstilling. I så fall, velg "Hun snakket norsk".

2. Bruk av tolk
   - ☐ Det ble brukt tolk
   - ☐ Partner oversatte
   - ☐ Annet familiemedlem/ venn oversatte
   - ☐ Ingen oversatte
   - ☐ Ikke opplyst

3. Var det en aktuell problemstilling ved besøket at kvinnen ikke visste om hun var omskåret?
   - ○ Nei, hun hadde kunnskap om at hun var omskåret
   - ○ Ja
   - ○ Ikke opplyst

4. Alder ved omskjæring
   - ○ Opplyst alder i år
   - ○ Som barn
   - ○ Som tenåring
   - ○ Etter fylte 18 år
   - ○ Ikke opplyst

5. Hvis opplyst alder i år, oppgi antall år

6. Omskåret i hvilket land
   - ○ Hjemlandet
   - ○ Annet land
   - ○ Ikke opplyst

7. Ved annet land, hvilket

8. Omskåret etter innvandring til Norge
   - ○ Ja
   - ○ Nei
   - ○ Fremgår ikke av journal

9. Omskåret av
   - ○ Tradisjonell omskjærer
   - ○ Helsepersonell
   - ○ Ikke opplyst

10. Tidligere åpning/ korreksjon av omskjæringen
    - ○ Ja
    - ○ Nei
    - ○ Ikke opplyst

    Save

11. Hvis tidligere åpning/korreksjon, årsak
    - ○ Fødsel
    - ○ Problemer med samliv
    - ○ Retinert menstruasjonsblødning
    - ○ Urinretensjon/lekkasje
    - ○ Infeksjon

- ○ Annet

12. Hvis tidligere åpning, reinfibulert?
    - ○ Ja
    - ○ Nei

13. Startet seksuelt samliv. Var eller har hun vært i et seksuelt forhold?
    - ○ Ja
    - ○ Nei
    - ○ Ikke opplyst

14. Tidligere svangerskap (Antall)

15. Levende fødte

16. Dødfødte

17. Keisersnitt

18. Er det registrert gynekologiske plager i pasientens journal?
    - ○ Ja
    - ○ Nei
    - ○ Uopplyst

19. Hvis gynekologiske plager, hvilke
    - ☐ Underlivssmerter
    - ☐ Menstruasjonssmerter
    - ☐ Smerter i magen
    - ☐ Dyspareuni (smerter ved samleie)
    - ☐ Samleie vanskelig/umulig å gjennomføre
    - ☐ Smertefull vannlating
    - ☐ Langvarig vannlating
    - ☐ Residiverende urinveisinfeksjoner
    - ☐ Urinlekkasje
    - ☐ Retinert menstruasjon
    - ☐ Fluor
    - ☐ Kløe
    - ☐ Infeksjoner i vulva/vagina
    - ☐ Cyster
    - ☐ Annet
    - ☐ Uopplyst

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Status og funn

1. Var hun gravid? (ved første konsultasjon)
   - ○ Ja
   - ○ Nei
   - ○ Usikkert
2. Hvis gravid, oppgi svangerskapsuke
   - [ ]
3. Var hun omskåret?
   - ○ Ja
   - ○ Nei
   - ○ Vurdert som usikkert
4. Omskjæringstype etter WHO klassifikasjon hvis angitt
   - ○ Type 1
   - ○ Type 2
   - ○ Type 3
   - ○ Type 4
   - ○ Annet
5. Hudsegl som dekker hele eller deler av vaginalåpningen
   - ○ Ja
   - ○ Nei
   - ○ Uopplyst
6. Beskrivelse hudsegl/vaginalåpning
   - ○ Hudsegl dekker det meste av vaginalåpningen
   - ○ Dekker en del fortil inkl. uretralåpningen
   - ○ Oppgitt hudsegl bredde i cm
   - ○ Beskrevet vaginalåpning med antall fingre
   - ○ Annen beskrivelse av vaginalåpning
   - ○ Ikke beskrevet
7. Oppgi antall cm
   - [ ]
8. Oppgi antall fingre
   - [ ]
9. Beskrivelse av klitoris
   - ○ Klitoris virker uaffisert
   - ○ Ser ut som klitoris er delvis fjernet
   - ○ Arrdannelse, klitoris palperes
   - ○ Klitoris palperes ikke
   - ○ Usikkert hvor mye som er fjernet
   - ○ Opplysninger mangler
10. Annen beskrivelse av ytre genitalia
    - ☐ Vulva ser normal ut
    - ☐ Cyste i vulva
    - ☐ Labia minora tilstede
    - ☐ Labia minora delvis fjernet
    - ☐ Labia minora fjernet
    - ☐ Labia minora ikke beskrevet
    - ☐ Labia majora delvis fjernet
    - ☐ Labia majora fjernet/nesten helt fjernet
    - ☐ Arrdannelse
    - ☐ Kelloid
    - ☐ Assymetrisk symmetri

- [ ] Striktur i vagina
- [ ] Perineum skadet
- [ ] Perineum ikke beskrevet
- [ ] Synlig uretra
- [ ] Annen beskrivelse av ytre genitalia
- [ ] Annet
- [ ] Uopplyst

Save

11. Hvis annen beskrivelse av ytre genitalia, angi

Max 255 characters. remaining.

12. Er det opplysninger om at undersøkelsen var spesielt smertefull eller psykisk belastende?

- ○ Bemerket i journalen at undersøkelsen gikk greit
- ○ Undersøkelsen var smertefull/belastende i samsvar med trange fysiske forhold
- ○ Undersøkelsen var smertefull/belastende uten trange fysiske forhold eller mer enn forholdene skulle tilsi
- ○ Undersøkelsen måtte avbrytes og det forelå trange fysiske forhold
- ○ Undersøkelsen måtte avbrytes pga smerter/psykisk reaksjon uten trange fysiske forhold eller mer enn forholdene skulle tilsi.
- ○ Ingen opplysninger om at undersøkelsen var spesielt smertefull/belastende for pasienten

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Behandling

1. Indikasjon for kirurgisk behandling
   - ○ Ja
   - ○ Nei
   - ○ Annet
2. Hvis annet, hva?
3. Fikk hun kirurgisk behandling?
   - ○ Ja
   - ○ Nei
   - ○ Opplysninger mangler
4. Åpning av infibulering (deinfibulering)
   - ○ Ja
   - ○ Ja, under fødsel
   - ○ Nei, pasienten var ikke infibulert
   - ○ Nei, pas ønsket ikke/bestemte seg ikke for åpning
   - ○ Nei, pasienten er deinfibulert fra tidligere
   - ○ Nei, av annen grunn
   - ○ Annet
5. Operatør
   - ○ Risa Lonnee Hoffmann
   - ○ Cecilie Hagemann
   - ○ Elisabeth Magnussen
   - ○ Jordmor
   - ○ Annen
6. Hvis annen, hvem
7. Åpnet fram til
   - ○ Urinrørsåpningen
   - ○ Klitoris/lenger fram
8. Annet kirurgisk inngrep, beskrivelse

   Max 255 characters. remaining.
9. Beskriv annen behandling

   Max 255 characters. remaining.
10. Anestesi
    - ○ Ingen
    - ○ Lokal
    - ○ Generell
    - ○ Spinal
    - ○ Annet
    - ○ Uopplyst

    Save
11. Opplysninger om at inngrepet var spesielt smertefullt
    - ○ Ja
    - ○ Nei
12. Opplysninger om psykiske reaksjoner under inngrepet

- ○ Ja
- ○ Nei

13. Hvis ja, beskriv evt. psykiske reaksjoner

Max 255 characters. remaining.

14. Avtalt kontroll

- ○ Ikke avtalt kontroll eller tlefonkontakt
- ○ Ja, avtalt kontakt på telefon
- ○ Avtalt kontroll
- ○ Uopplyst

15. Opplysninger om kontakt eller hendelser etter behandling

- ○ Ja
- ○ Nei

16. Årsak til kontakt eller hendelser etter behandling

- ○ Komplikasjoner
- ○ Råd
- ○ Annet

17. Hvis komplikasjoner, angi hvilke

Max 255 characters. remaining.

18. Hvis annet, angi

Max 255 characters. remaining.

19. Eventuelle andre relevante opplysninger

Max 255 characters. remaining.

Beskriv eventuelle andre forhold/hendelser av betydning ved denne pasienten/ sykehistorien/behandlingen

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