Catheterization of the urethra in girls

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To the Editor: As Manzano et al. noted in their Video in Clinical Medicine (July 10 issue), it is sometimes difficult for the examiner to identify the urethral meatus when attempting to perform catheterization of the urinary bladder in girls. In such instances, it may be helpful to draw the labial tissue upward by moving the nondominant hand anteriorly after spreading the labia majora with two fingers.

If the meatus remains hard to visualize, we suggest enlisting an assistant for the following maneuver, which we term “labial lift.” Both the examiner and the assistant should gently grasp one of the labia majora — the examiner on the side of her nondominant hand and the assistant opposite. Together, they lift the labia anteriorly, laterally, and caudad (Fig. 1). As shown in the figure, using the corner of a small piece of sterile gauze helps to maintain a comfortable hold on the labia, which may become slippery after sterile preparation. We have found that this technique seldom fails to allow the necessary visualization of the meatus.

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The authors reply: This is a very nice alternative to the use of downward traction to the cephalad fold of the vaginal introitus downward.

Figure 1. Labial Lift to Expose the Urethral Meatus in Girls.
The examiner gently grasps the labium majus on the side of her nondominant hand, while the assistant does so on the opposite side. Together, the labia are lifted anteriorly, laterally, and caudad to allow visualization of the urethral meatus.

Figure 1. Downward Traction of the Vaginal Mucosa.
The examiner localizes the meatus by gently pulling the cephalad fold of the vaginal introitus downward.

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alad fold of the vaginal introitus that we presented in the video (Fig. 1). The difficulty of these techniques resides mainly in the fact that the procedure must be sterile.

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A New Multidrug-Resistant Strain of Neisseria gonorrhoeae in Australia

TO THE EDITOR: In 2013, the Centers for Disease Control and Prevention identified Neisseria gonorrhoeae antimicrobial resistance as being an urgent threat. Ceftriaxone monotherapy or dual therapy with azithromycin is now the mainstay of treatment for gonorrhea, and no ideal alternatives have been identified. There have been three sporadic reports of two ceftriaxone-resistant strains of N. gonorrhoeae in the past 5 years: H041 and F89 (Table 1).1-3 H041 was identified in only a single case involving a female sex worker in Japan in 2009.1 F89 was initially reported in France in 2010 in a man who has sex with men2 and subsequently was detected in Spain in two sexually related men who have sex with men.3 Neither H041 nor F89 has since been reported.

Here we report a third gonococcal strain that is a cause for public health concern. The A8806 strain, which was identified in Australia in late 2013, was shown to have a minimum inhibitory concentration (MIC) of ceftriaxone of 0.5 mg per liter (Table 1) when measured according to the calibrated dichotomous sensitivity method. The isolate was obtained from a genital swab obtained from a young female European traveler with vaginal discharge who presented to a medical clinic in central Australia in December 2013. She was tested for sexually transmitted infection and treated with metronidazole. She had reported sex with a new partner, who was a fellow European traveler, 1 week previously in Sydney. The patient then traveled from central to northeastern Australia, where she presented with ongoing vaginal discharge to a second clinic and indicated that she had by then received a telephone call from the first clinic confirming a positive test result for gonorrhea. She was treated with ceftriaxone at a dose of 500 mg administered by means of intramuscular injection and azithromycin 1 g orally, and she was reportedly culture-negative for gonorrhea approximately 2 months later.

Genetic analyses showed that the A8806 isolate had key similarities to H041 (Table 1). Notably, A8806 had a mosaic penicillin-binding protein 2 with two of three key substitutions4 leading to ceftriaxone resistance in H041 (A311V and T483S, but not T316P) (Table 1). The A8806 strain also shared the same multilocus sequence type as H041 but differed from H041 in the N. gonorrhoeae multiantigen sequence type (Table 1). Previous pharmacodynamic analyses have predicted that treatment failures are likely for strains with an MIC of 0.5 mg per liter with the use of ceftriaxone monotherapy at doses of 250 mg and 500 mg.5 Thus, this isolate arouses new concerns over the ongoing efficacy of ceftriaxone monotherapy for treatment of gonorrhea. Data are lacking to determine the prevalence and spread of the A8806 strain in Australia and elsewhere.

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