

A CASE REPORT

Surgical Treatment of Complication of Female Genital Mutilation in Pikine Hospital, Senegal

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Abstract

We share our experience on reconstructive for surgery female genital mutilation. This is a retrospective study of all cases of female genital mutilation surgery performed in Pikine National Hospital. We have reviewed the various indications and surgical techniques used. We collected 8 cases of clitoral cyst and 6 cases of closed vaginal opening. The surgery of clitoral cysts was to perform cystectomy followed by nymphoplasty. The closing of the vaginal opening required defibulation together with clitoroplasty according to the wishes of the patient. The anatomical and functional outcomes were satisfactory. Female genital mutilation surgery requires a good knowledge of vulvar anatomy. The various surgical indications must meet the expectations of patients to guarantee their satisfaction. (*Afr J Reprod Health* 2017; 21[1]: 122-125).

Keywords: Female Genital Mutilation, Complications, Defibulation, Clitoroplasty, Cystectomy

Résumé

Nous partageons ici notre expérience en chirurgie reconstructive pour les mutilations génitales féminines. Il s'agit d'une étude rétrospective de tous les cas de chirurgie de mutilation génitale féminine réalisés à l'Hôpital national de Pikine. Nous avons examiné les différentes indications et techniques chirurgicales utilisées. Nous avons recueilli 8 cas de kyste clitoridien et 6 cas d'ouverture vaginale fermée. La chirurgie des kystes du clitoris était d'effectuée avant de faire une cystectomie suivie d'une nymphoplastie. La fermeture de l'ouverture vaginale nécessitait une défibulation avec une clitoroplastie selon les souhaits de la patiente. Les résultats anatomiques et fonctionnels étaient satisfaisants. La chirurgie des mutilations génitales féminines exige une bonne connaissance de l'anatomie vulvaire. Les différentes indications chirurgicales doivent répondre aux attentes des patientes pour garantir leur satisfaction. (*Afr J Reprod Health* 2017; 21[1]: 122-125).

Mots-clés: Mutilation génitale féminine, Complications, défibulation, clitoroplasty, cystectomie

Introduction

Female genital mutilation (FGM) is still very common despite being banned in many countries. In Senegal, according to UNICEF, FGM affects 26% of women aged 15 to 49 years^{1,2}. Like the African continent, the prevalence of FGM in Senegal varies according to place of residence and ethnicity. The proportions of circumcised girls are higher in rural areas (34%) than in urban areas (22%), and most ethnic groups concerned by these practices are the Mandingo (82%), Soninke (65%), Pular (65%) and Diola (52%). The practice

remains insignificant among Serere (2%) and Wolof (0.9%)¹. FGM sometimes cause complications the treatment of which is primarily surgical; i.e. partial closure of the vaginal orifice and clitoral cysts. We report our experience on how to surgically deal with these complications. We compiled information relating to the patients admitted in our care unit for FGM complications requiring surgery. Patients who did not want surgery and those who did not require it were not enrolled in the study. We collected 8 cases of clitoral cyst and 6 cases of closed vaginal opening. The different indications and the operative

techniques performed were reviewed.

Cases report

The average age of patients was 23.2 years (14-38 years). They were all from the Pular or Mandingo ethnic groups who generally carry out such practices in Senegal. Eight cases out of the fourteen were married. Three cases were discovered due to failure in intercourse attempt on wedding night. There was type 2 FGM in 69% of patients, and type 3 in 28.5% of cases (Table 1). All these women were submitted to the practice during childhood. The timeline for the development of the cyst was variable (10 to 20 years), and some of them even waited more than four years before seeing a gynecologist. The main reasons for consultation were aesthetic discomfort (8 cases), absolute impossibility of having sex (4 cases), and desire for clitoral repair (one case). The clitoral cysts were in the form of a rounded painless mass, 10 to 13 cm in diameter, seating in the nymphectomy area, blackish, renitent, non-pulsatile, sessile and movable superficially and in depth. The overlying skin was normal (Figure 1). The infibulations appeared in the form of apposition of the labia minora and majora reducing the vaginal opening into a sluce that would just let menses trickle out (Figure 2 and Figure 3). The patients with clitoral tumor had cystotomy incisions directly closed without related clitoroplasty. The purpose of defibulation was to separate labia minora from labia majora in order to obtain sufficient vagina permeability for intercourse. Two cases of clitoroplasty were made on patients' request (Figure 4). The aftermath of surgery was uneventful with healing and resumption of sexual activity after 45 days on average with extremes of 19 and 60 days. No recurrence has been met so far.

Discussion

Two types of FGM complications necessarily rely on surgery: vulvar closure (Type 3) and anatomical distortions represented by clitoral cysts. These complications are not rare but are often diagnosed late during the wedding night or when the cyst becomes annoying or unbearable. The clitoral cysts are due to sub-dermal inclusions of epithelial fragments or a reversal of the wound edges at the time of healing of the excision³⁻⁴.



Figure 1: Clitoral Cyst Aggravating Type 2 FGM
1a and 1b: Cysts located next to female genital mutilation area in a 14 years old girl. Note well the obstructive nature of the cyst which may be an impediment to sexual intercourse.
1c and 1d: Results 3 months after a simple cystectomy without clitoroplasty.



Figure 2: Closure of Vulva (labia majora) after Type 3 FGM
2a and 2b: Closure of the labia majora with a small sluce just allowing menses and urine to trickle out in a 20 years old woman. The patient was examined for vaginal impotence the day after her wedding night. **2c and 2d:** Defibulation using a groove probe and a scalpel blade, making bare the labia and vaginal orifice. Marriage is consummated 10 days after.

Table 1: Profile of Patients with FGM

Case	Age (years)	Parity	Type of FGM	Background circumstances	Complications	Actions
1	22	0	2	-	Cyst	Cystectomy
2	25	1	2	-	Cyst	Cystectomy
3	25	2	2	-	Cyst	Cystectomy
4	31	2	2	-	Cyst	Cystectomy
5	38	1	2	-	Cyst	Cystectomy
6	24	1	2	-	Cyst	Cystectomy
7	19	0	2	-	Cyst	Cystectomy
8	19	0	2	-	Cyst	Cystectomy
9	20	0	3	Apareunia	Closure of vulva	Cystectomy
10	14	0	2	-	Cyst	Cystectomy
11	20	0	3	Apareunia	Closure of vulva	Defibulation
12	26	0	3	Apareunia	Closure of vulva	Defibulation and clitoroplasty
13	27	2	2	-	Anorgasmia	Clitoroplasty
14	15	0	3	Dysuria	Closure of vulva	Defibulation



Figure 3: Closure of the Vulva (labia minora) after Type 3 FGM

3a and 3b: Incomplete closure of the labia minora showing the anarchic nature of the complications of FGM. A first attempt to perform traditional defibulation in this 27 years old patient. Debridement helped remove the vaginal obstruction.

These usually aggravate Type 2 FGM as demonstrated in our report. They cause psychosexual discomfort with serious consequences on the quality of life of the couple; secondly, the swelling may have an obstructive effect by jeopardizing sexual intercourse^{2, 5}.

Vulvar closure is especially due to infibulation with obstruction of the rima vulvae. Ways of achieving this differ across regions; however, the complications are similar: urinary problems, repeated genital infection and especially apareunia. Whatever the complications, surgical

treatment should comply with one fundamental principle: it must be adapted to the area where the patient lives, hence responding to the patients' main concern that is to recover the anatomy they are accustomed to (restoration of the labia minora without clitoroplasty). Indeed, these patients did



Figure 4: Closure of the Vulva (labia minora) after Type 3 FGM

4a and 4b: Closure of the labia minora with areneunia in a 27 years old woman who was examined the day after her wedding night. The couple also wanted reconstruction of the clitoris.

4c and 4d: Results on day10 (4c), then in month 3 (4d) after defibulation and reconstruction of the clitoris.

not expect to undergo clitoroplasty because they grew up and developed their sexuality without their clitoris. This reconstruction of the clitoris might be experienced as a loss of sexual identity. The two patients who requested for clitoral restoration did not have the same upbringing as the rest of the patients. A recent systematic review of Abdulcadir et al⁶ recommends that women seeking clitoral reconstruction be made aware of the

scarcity of available data on the effectiveness of this surgical technique. Further research is also needed on the safety and efficacy of the procedure for identifying the long-term results which could be beneficial to women.

Conclusion

In Senegal, the prevalence of FGM / C, which is 26%, has not been significantly reduced despite the strategies for its abandonment. Anatomical complications such as clitoral cyst or vaginal closure are usually the only reasons for consulting. The demand for clitoris repair is exceptional. Clitoral cysts and vaginal closures secondary to FGM require a simple intervention that meets the wishes of the patient. However, a good outreach strategy should be set up to deal with these complications in due course.

Conflicts of Interest

The authors declare no conflict of interest

Contribution of Authors

All authors mentioned in the article approved the manuscript.

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