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Female Circumcision Complicated by Vulva Adhesion and Emergency Cesarean Delivery: A Case Report

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Abstract

It took a long time for the world to eventually agree that female circumcision was an avoidable mistake and to take actions to abolish it. For those subjected to the practice, many endure life without serious consequences but some can suffer serious and irreversible physical, psychological and psychosexual complications. We report a 20 years old female who had neonatal ritual circumcision which was complicated by vulva adhesion in childhood and emergency cesarean delivery in her adult life. It is our earnest hope that by reporting cases like this any people, culture or country, that still harbor sympathy for this unfortunate practice will be convinced to end it.

Keywords: ***Female genital mutilation/cutting (FGM/C); Psychosocial difficulties; Vulva reconstruction; Obstetric***

1. Introduction

Female genital mutilation/cutting (FGM/C) includes procedures involving partial or total removal of the external genitalia of females for non-therapeutic reasons [1].

WHO has defined four types of FGM/C (BOX 1) and the type performed vary between countries, ethnic groups and age groups.

BOX 1

WHO classification of female genital mutilation.

Type 1: Partial or total removal of the clitoris[a] and/or the prepuce (clitoridectomy).

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Type Ia: Removal of the clitoral hood or prepuce only.

Type Ib: Removal of the clitoris[a] with the prepuce.

Type II: Partial or total removal of the clitoris[a] and the labia minora, with or without excision of the labia majora (excision)

Type IIa: Removal of the labia minora only.

Type IIb: Partial or total removal of the clitoris[a] and the labia minora.

Type IIc: Partial or total removal of the clitoris[a], the labia minora, and the labia majora.

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and apposition the labia minora and/or the labia majora, with or without excision of the clitories (infibulation).

Types IIIa: Removal and apposition of the labia minora.

Type IIIb: Removal and apposition of the labia majora.

Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, and cauterization.

([a]When total removal of the clitoris is reported, it refers to the total removal of the glans of the clitoris).

FGM/C has been practiced for centuries and has established its roots in ancient socio cultural traditions, and despite the implementation of laws prohibiting this practice, it is still performed in many countries in Africa, and in few in the Middle East and Asia [2].

Worldwide it is estimated that 200 million girls and women have undergone FGM/C [3] and >3 million girls are at risk of cutting every year [4]. A wide range of complications complicating FGM/C has been reported. Severe pain, bleeding, shock, infection and septicemia, and injury to adjacent tissues are the main early causes of morbidity and occasional mortality associated with this practice. Keloid scars, dermoid or inclusion cysts, vulva adhesion, recurrent urinary tract infections, fertility, sexual, and birth difficulties occur late and can cause medical, psychological and socioeconomic problems. Women who have undergone circumcision may suffer any or many of its complications for life, and some of these complications can lead to shortened life expectancy.

2. Case Report

N.O is a 20 years old primi-gravida who was referred to our secondary care hospital from a traditional birth attendant (TBA) in the early stage of labour. She was referred because the TBA felt the vulva could not allow passage of a baby for normal vaginal delivery. Her abdominal pain which was colicky and of increasing severity and radiating to the low back started four hours before presentation. There was no ‘bloody show’ or passage of water per vaginum. There was accompanying trans-abdominal obstetric ultrasounds scan taken 5 days ago showing at term normal, mature, male fetus in longitudinal lie, cephalic presentation, with fetal weight of 2.9 kg and fetal heart rate of 143 beats/minute, with a mature placenta in a fundal in position and adequate liquor amni. She also presented a laboratory result showing normal blood and urine parameters. She wanted a cesarean delivery. Her systemic inquiries did not reveal any abnormal complaints.

She was circumcised in early infancy and was told her vulva wound healed well. However, in childhood she could remember many hospital attendances for vulvo-vaginal discharge, and itching, requiring vaginal pessaries or frequent dysuria requiring

oral drugs. Her menarche was at 14 years of age and this was accompanied by severe dysmenorrhea and poor flow which got worse with subsequent cycles.

She finished secondary school and has being attempting entrance examinations for higher school admission without success. She felt she was physically normal until her first attempt at sexual intercourse after secondary school. Despite many attempts by her boyfriend, he could not penetrate her introitus and at subsequent attempts when he eventually succeeded, it was very painful. She tried to avoid intercourse but her boyfriend was always persistent and patient that made the act bearable and resulted in her becoming pregnant soon after her first sexual experience. She got married and became the first to do so, when she has an elder sister who is yet to marry. She is the 3rd in a family of seven children - 3 females and 4 males - all circumcised. Her parents were also circumcised.

On physical examination she was in obvious pain distress with frequent, strong uterine contractions. Her vital signs were T-37.0c; RR-23 breaths/minute, P-80 beats/minute and BP- 90/55 mintlg (supine). Fundal height was at 38 weeks, and PHT-142 beats/min, regular and the head presenting was engaged.

Inspection of the perineum showed a fused labial minora with a small circular opening near the fourchette (FIG. 1). She declined our advice to do a digital vaginal examination and requested for a cesarean section. Written consent was obtained and she was prepared and anaesthesized with intravenous ketamine hydrochloride. Examination of the vulva under anaesthesia revealed there were two small openings, the larger admitting 2 fingers only. A size 14F catheter was passed through the openings (FIG. 2) and gentle traction forwards was able to lyse the adhesion to reveal a normal introitus and to successfully pass a urethral catheter (FIG. 3 & 4). A cesarean section was done successfully with delivery of a life male baby. She recovered excellently and was discharged on the 4th day post-operation. She was seen on the 10th post-operative day to remove sutures from a well-healed wound and to inspect her vulva wound which has also healed. She was happy with the appearance of her vulva and said she urinates very freely since her vulva procedure.

FIG.1. **Vulva with a small opening near the fourchette.**

FIG. 2**. Fused labial minora with two small openings.**

FIG. 3. **Size 14F Forley catheter used for adhesiolysis.**

FIG. 4. **Catheter in situ under anaesthesia.**

3. Discussion

This unfortunate lady had FGM/C as a neonate which became complicated by labial adhesion in early childhood. Despite visiting some health facilities in childhood for vulva infections, the care givers never entertained or prevented the subsequent development of labial adhesion with severe vulva stenosis causing physical and sexual problems. Care givers in FGM/C endemic areas should be trained to provide professionally necessary health and sex education [4,5]. Her menstrual problems were never actually presented to a gynecologist and she managed her sexual difficulties alone. She became pregnant unintentionally and ended up with poor antenatal care at a traditional birth attendant before presenting to us, un-booked, for cesarean delivery.

Vulva adhesion after FGM/C is often associated with those infibulated [6]. In the less severe forms of FGM/C adhesion can occur as a result of recurrent vulvo-vaginitis which was not well managed in childhood, this may be due to low estrogen levels of females before puberty and the restrictions in the drainage of natural secretions and later menstrual blood because of vulva occlusion [7,8].

Many health consequences of FGM/C related to pregnancy and delivery have been described [9]. In a 2006 African multicenter study on 28393 women with FGM/C, there were increased risk of prolonged labour, perineal trauma, post-partum hemorrhage and cesarean section, relative to women without it [11]. Moreover, infants born from such mothers were at increased risks of still births, and early neonatal deaths estimated to lead to an extra 1-2 peri-natal deaths per 100 deliveries [11]. There were multiple consequences of FGM/C in this patient. Her childhood was complicated by severe genito-urinary infections which led to vulva adhesion. She had serious psychosexual trauma as an adolescent with severe dysmenorrhea, dyspareunia, unplanned pregnancy and marriage and discontinuation of her education after secondary school. When she became pregnant, despite tight introitus, Rushwan, her antenatal care was secretly done by a traditional birth attendant because she was ashamed of exposing her "abnormal" vulva to the orthodox medical public. Perhaps earlier visit to a gynecologist could have resulted in successful adhesion-lysis before labour and maybe vaginal delivery [12,13]. Finally, she ended up with a cesarean delivery with its attendant high risks and higher costs.

4. Conclusion

The world is united in efforts to abolish FGM/C everywhere. For those already circumcised, we must be ready to offer necessary assistance to overcome the various complications they might develop. In Nigeria success in this regard will be easier with empathy than with anger or litigation.

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