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Genital restorative surgery after female genital cutting

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Seifeldin A
Department of Urogynecology & Cosmetic Gynecology, El Galaa Teaching Hospital for Women, Egypt

Correspondence: Seifeldin A, Department of Urogynecology & Cosmetic Gynecology, 12 Degla st. Mahandessine, Giza 12411, Cairo, Egypt, Tel +2-0100-5250230; +2-0122-3675300, Email a.seifaldin@gmail.com

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Introduction

Female genital mutilation/cutting (FGM/C), aka female circumcision, is defined by the World Health Organization (WHO) as "All procedures that involve partial or total removal of the external female genitalia for non-medical reasons".[1] Practiced in Africa and other parts of the world, the WHO recently estimated that over 250 million females have been circumcised so far, and an additional three million are at risk of circumcision each year, nearly 8000 cases a day.[2] First recorded in Egypt in the 5th Century BC, and noted on a papyrus from Memphis in 2nd Century BC, its historic background goes back more than 3000 years. Some ancient Egyptian mummies were found to have been circumcised. FGM/C awareness has increased globally in the past 20 years, due to an increased influx of African immigrants and refugees, with 680,000 cases in Europe and 513,000 in the United States, putting a heavy burden on the healthcare systems of the host countries. It is a destructive procedure, banned by law in most countries, and considered against a crime humanity.[3]

The area excised usually includes the:

a) Clitoris

b) Clitoral hood

c) Labiaminora

d) Labiamajora

FGM/C has no medical benefits; the reason for the practice is purely social with a false religious pretext in some cases. It is usually performed before puberty, but can be done at any age.[4]

FGM/C in practicing communities is regarded as:

a) Purification and cleanliness

b) Perquisite for growing into womanhood

c) Preserves virginity and family honor

d) Provides better marriage prospects for girls

e) Prevents promiscuity and adultery

f) Saves face for family within the community

Types

The WHO classifies FGM/C in four types with varying degrees of cutting, ranging from a simple nickon the prepuce, clitoral excision, labial amputation, to complete infibulations (Figure 1). Under this classification, aestheticgynecology procedures such as labiaplasty and clitoral hood reduction can unjustifiably be categorized as FGM. While aesthetic genital surgery and FGM share similarity in modifying the female genitalia, they differ in consent and intent. FGM victim is usually a minor, excision is done without consent, and with intent to cause harm and diminish sexual pleasure.

Type I: Partial or total removal of the clitoris* and/or the prepuce (clitoridectomy)
Type Ia: Removal of the clitoral hood or prepuce only
Type Ib: Removal of the clitoris* with the prepuce
Type II: Partial or total removal of the clitoris* 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* and the labia minora
Type IIc: Partial or total removal of the clitoris,* 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 clitoris (infibulation)
Type 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, scraping and cauterisation

* In the World Health Organization classification, when there is reference to removal of the clitoris, only the glans or the glans with part of the body of the clitoris is removed. The body or part of the body and the crura of the clitoris remain intact as well as the bulbs, two other sexual erectile structures.

Figure 1 World health organization classification of female genital mutilation.

Complications of FGM/C

a) Hemorrhage, neurogenic shock, sometimes leading to death

b) Infection by HIV, hepatitis and tetanus

c) Trauma to surrounding structures (urethra and vagina)

d) Implantation inclusion cysts, clitoral neuroma, keloid and scar tissue formation

e) Decreased clitoral response in desire, arousal and orgasm

f) Increased maternal-fetal morbidity and mortality

g) Pain, dyspareunia and dysmenorrhea

Psycho-sexual disturbances:

a) Low self esteem, shame, embarrassment with partner

b) Post-traumatic stress disorder

c) Anxiety and psychosomatic disorders

d) Flash back to traumatic event

Management

- The complexity of symptoms is best managed by a multidisciplinary approach provided by a group of gynecologists, psychologists, sexologists, midwives and social workers. Main guidelines are psycho- sexual assessment, sexual education, comprehensive physical exam, and surgery if needed (defibulation, clitoral restoration, and labial reconstruction).
- **Cognitive Behavior Therapy:** by a trained psychotherapist has proven to be of benefit for traumatized FGM patients, sexual education by a sexologist is also an important asset in therapy. These measures improve and stabilize personal confidence, self esteem, body image identity, partner relationship, and enhance sexual desire, arousal, sexual response, and orgasmic capacity by the improved mood state; with or without reconstructive surgery.

Defibulation

In some African communities, the clitoral body is partially excised and both labia (minora and majora) are cut and the skin gap is sutured together forming a covering skin seal acting as a chastity belt and creating a small opening at the lower end of the vagina for urine and menstrual flow (Figure 2). This is called Pharaonic infibulation, and in some cases the opening is too narrow to allow consummation of marriage and a surgical procedure known as defibulation is performed to open the vulva skin cover to allow sexual contact[5] Defibulation can be performed under local or general anesthesia, the covering skin seal is cut by a scalpel or scissors after protection of the underlying urethra by an instrument. The incision is extended upwards until the urethra is completely visualized. The tissue gap on both sides is then approximated using a running 4-0 monocyl sutures, with the addition of superficial interrupted absorbable 4-0 vicryl sutures on the shin. Clitoral and labia minora reconstruction may be performed at this stage or later depending on situation after the defibulation, patient desire and expectations.[6]

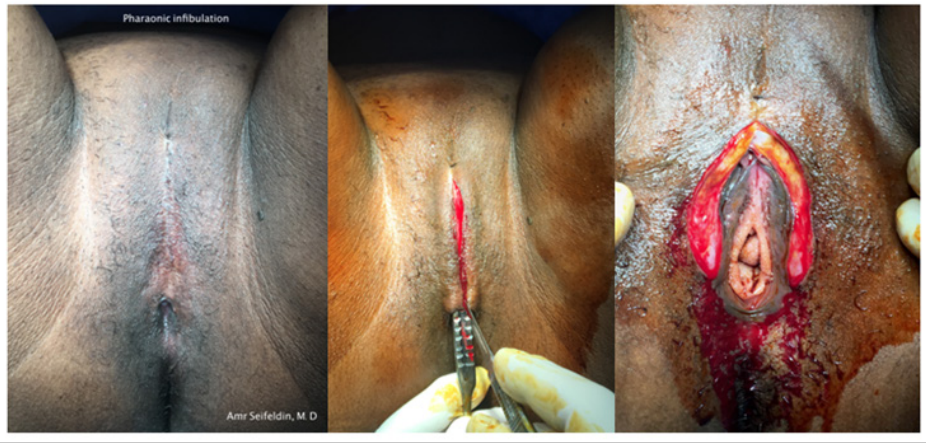

Figure 2 Defibulation.

Clitoral reconstructive surgery (CRS)

FGM/C victims still retain the ability to reach orgasm after clitoral excision, the clitoris is a highly sensitive organ and can be modified to function as a new clitoris.[7] Although many FGM/C victims are unaware of the availability of genital reconstructive surgeries, the demand for genital reconstructive surgery both for functional and aesthetic reasons, has dramatically risen in past years due to increased patient awareness, better education, and modern aesthetic and sexual health trends.

Methods

a) Removing peri-Clitoral adhesions

b) Removing clitoral inclusion cysts & clitoral neuromas (if present)

c) Releasing and mobilizing the clitoris by cutting the suspensory ligament

d) Preserving the dorsal neurovascular bundle

e) Restoring clitoris to its normal anatomical position in the frenulum

The prepuce skin is cut longitudinally over the clitoral stump with a scalpel, and the fibrous tissue around the clitoral stump is removed. The suspensory ligament is cut close to the Bone, freeing the clitoris to allow sufficient mobilization; while preserving the dorsal neurovascular bundle. Vicryl 3/0 sutures were used to fix the tip of the neo-clitoris inferiorly at 5 & 7 O'clock to the vestibular skin (frenulum) to prevent retraction; additional interrupted sutures are carefully placed fixing the sides of the clitoral body to underlying structures. When there isn't enough skin and the frenulum has been previously removed during the circumcision process, the clitoris is left uncovered and is covered by skin in eight weeks, this technique was devised by Dr. Pierre Foldes (Figure 3). The clitoris can also be relocated in the frenulum when it is present to give a more natural appearance (Figure 4).

Platelet Rich Plasma (PRP) injections directly into the clitoris, improve clitoral sensitivity by increasing blood flow, growth factors

and stimulating stem cells in the region.[3] Postoperative follow-up, counseling and reassurance provide a holistic management protocol for FGM victims.

Results: A palpable glans was noted in 85% of cases with improvement of aesthetic appearance 90%, clitoral function (sensitivity & pleasure) 63%, sexual desire 51%, and decrease in pain by 21%. Other studies results show overall improvement in sexual function, lubrication, and orgasm intensity. However psycho-sexual improvement 88-96% was the greatest due to improved self confidence, body image identity, and psychological well being. On the negative side, post operative complications (5-11%) were noted as hematomas, infection, & wound dehiscence). Some patients complained from decreased sexual pleasure 2.5%, sexual desire 2%, pain 8%, and orgasmic dysfunction 18%. These complications improved over a 6-12 month time period and PRP injections.[3,8,9] Better results were found in young adult women with bettereducation and higher socio-economic status, with type I and type II FGM/C; which are probably attributed to the psychological benefits of the procedure, which far exceed the physical benefits.[3]

Figure 3 Removing peri-clitoral adhesions.

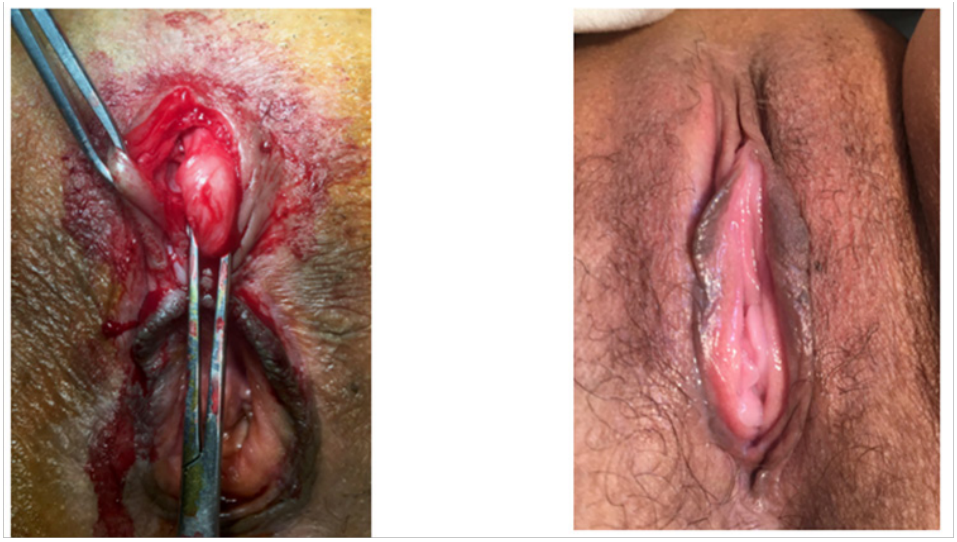

Figure 4 Clitoral Reconstruction 5 months post op.

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Conclusion

FGM rates are declining globally due to changing socio-cultural and economic factors. Genital restorative surgeries have provided hope for FGM/C victims to regain their dignity, improve sexuality and quality of life. We have noted an improvement in aesthetic appearance and reported functional outcome, improvement in self-confidence, female self-image, partner and parent relationships after the procedure and support. Refinement of technique has decreased postoperative complications. We therefore suggest that genital reconstructive procedures should be made available to FGM/C victims in need of it. The possibility of such surgeries should be more widely promoted in hospital and communities where patients are presenting with aesthetic and sexual function complaints. Finally, it is important to be able to meet increased demand, through training more surgeons in the art of female genital reconstructive surgery.

Acknowledgments

None.

Conflicts of interest

Authors declare that there are no conflicts of interest.

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