J Pediatr Adolesc Gynecol (2010) 23:336–340

Original Study

Post Genital Mutilation Giant Clitoral Epidermoid Inclusion Cyst in Benin City, Nigeria

Osarumwense David Osifo, FWACS, FICS
Pediatric Surgery Unit, Department of Surgery, University of Benin Teaching Hospital, Benin City, Nigeria

Abstract. *Objective:* To report overall occurrence, and the mode of presentation and management of girls with post genital mutilation giant clitoral epidermoid inclusion cyst in an African subregion.

Methods: This is a prospective experience with female patients who presented at two centers in Benin City, Nigeria, between January 2005 and December 2009 with clitoral epidermoid inclusion cyst following underground traditional female genital mutilation performed on neonates.

Results: In total, 37 patients were seen with clitoral epidermoid inclusion cyst, 15 (40.5%) were post pubertal girls who could no longer cope with giant cyst that measured more than 3.5 × 6.5 cm in size at an average age of 17 (range 14–21) years. Ignorance, financial constraints, and the fear of possible prosecution by anti-female genital mutilation agencies were reasons for late presentation. Consequently, rapid increase in size of all cysts (100%), mass effect producing dragging discomfort in the vulva of 14 (93.3%) girls, social stigmatization of 12 (80%) girls by peers and spouses, sexual difficulty experienced by 10 (66.7%), and irritating bulge in the perineum of 10 (66.7%) girls, were the most common indications for surgical consultation. Outcomes of cystectomy that included total clitoridectomy performed on on an outpatient basis mainly with local anesthesia were encouraging with no incidence of recurrence recorded on 1-4 years postoperative follow-up.

Conclusion: Late presentation of girls with giant post genital mutilation clitoral epidermoid inclusion cysts was common. More campaigns against female genital mutilation and government policy aimed at encouraging patients with complications to seek early medical attention, and free treatment for those who present early are advocated.

Address correspondence to: Osarumwense David Osifo, FWACS, FICS, Pediatric Surgery Unit, Department of Surgery, University of Benin Teaching Hospital, Benin City, Nigeria; E-mail: Leadekso@yahoo.com

1083-3188/$36.00
doi:10.1016/j.jpag.2010.02.006

Key Words. Female—Genital—Mutilation—Epidermoid inclusion cyst

Introduction

Epidermoid inclusion cysts may occur following trauma, usually from ingrowths or implantation of epidermal tissues underneath other tissues.[1] The accumulation of epidermal desquamations, secretions and other debris that cannot find exit to the exterior, form a cystic and often painless swelling that gradually increases in size over time. Unlike the congenital dermoid cysts that are usually found in the midline of the body, acquired epidermoid inclusion cysts can occur anywhere in the body. Most commonly affected sites include the soles of the feet of people who walk unshod and the palm of the hands and fingers of manual laborers such as farmers.[2,3] Involvements of different parts of the body, including the clitoris, have been described by many authors.[1–8] Clitoral epidermoid inclusion cyst may occur following trivial trauma to the clitoris, such as vulval dermatitis, but the majority of cases occur as a complication of female circumcision (genital mutilation) that is still a very common practice in many cultures, especially in Africa where the procedure is commonly performed on neonates.[4,8–12]

Despite the various types of complications that have been reported following female genital mutilation and the governmental and non governmental campaigns against the practice, there has been an increasing number of female children presenting late with post mutilation complications in this subregion.[10,11,13] These were traced to underground practice by quacks and the fear in affected families of a possible prosecution by anti-female genital mutilation organizations.[10,13] Consequently, many affected female children may not seek early surgical consultation unless the complication is life threatening or they

are no longer able to cope with the associated discomfort.[8,10,11,13] The non-life threatening and often painless nature, and the hidden location of clitoral epidermoid inclusion cyst, make it an easily concealed complication of female genital mutilation.

Here, we report our experience with the overall occurrence, and the mode of presentation and management, of consecutive girls who had genital mutilation as neonates but presented after puberty at two centers in an African subregion with giant clitoral epidermoid inclusion cyst.

Patients and Methods

This is a five-year prospective experience on the mode of presentation and management of clitoral epidermoid inclusion cyst at the Paediatric Surgery Unit of the University of Benin Teaching Hospital and Leadeks Medical Centre, both in Benin City, Nigeria, between January 2005 and December 2009. Benin City is the capital of the densely populated Edo State with an average population of four million people, comprising mainly of the Edo ethnic group. The people believed strongly and practiced both male and female circumcision until recently when public outcry against female genital mutilation drove it (female circumcision) underground. The type and extent of female genital mutilation performed by the people is a spectrum from clitoral tip excision (type I), through complete clitoral excision (type II), to complete clitoral and labia minora/inner layer of labia majora excision (type III). The focus of this present study is on the post genital mutilation giant clitoral epidermoid inclusion cyst subtype. In the context of the study, therefore, 'giant clitoral epidermoid inclusion cyst' refers to such a cyst that was estimated to be 3.5 × 6.5 cm (transverse and longitudinal diameter) or more in size and bulges beyond the labia majora (Figs. 1 and 2). We distinguish this from the more common smaller clitoral epidermoid inclusion cysts, hidden by the labia majora, which are usually seen after circumcision (mutilation) and easily excised in younger children. Consecutive patients who were diagnosed with clitoral epidermoid inclusion cyst were included after local ethical approval was obtained from the Leadeks Medical Centre and a consent form that met WHO-Helsinki declaration standard was duly signed by each patient or their parents. A checklist of questions was used to determine the range of symptoms for both the small and giant clitoral epidermoid inclusion cysts. The biodata, etiology of the clitoral cyst, place/personnel who performed the mutilation, immediate complications, onset of cyst formation, reasons for late presentation, mode of presentation, treatment, challenges, and outcome were collated on pre-structured forms.

Fig. 1. An 18-year-old girl who had traditional genital mutilation as a neonate. She presented with giant clitoral epidermoid inclusion cyst that measured 5.2 × 9.8 cm.

Statistical Analysis

The data obtained were entered into Microsoft Office Excel 2007 sheet and analyzed as counts, frequency and percentages, while continuous data were expressed as mean/standard deviation.

Results

In total, 37 female patients were seen with clitoral epidermoid inclusion cysts during the period of the study. Of these, 22 (59.5%) children were presented by their parents/caregivers before they were aged 9 years with small hidden cysts that were promptly excised. However, 15 (40.5%) post-pubertal girls

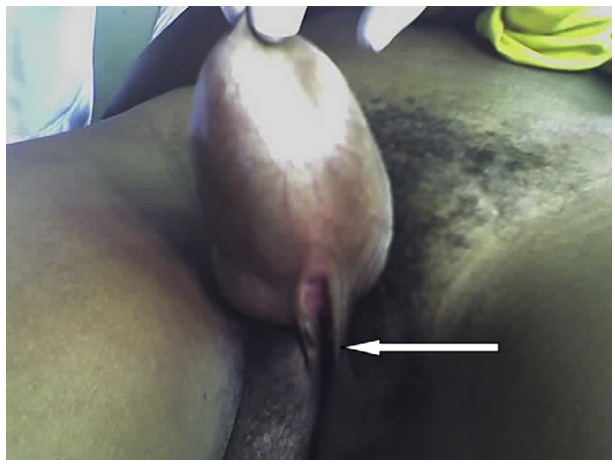

Fig. 2. A 21-year-old girl with post genital mutilation giant clitoral epidermoid inclusion cyst (6.2 × 10.1 cm). Note the labia minora concealing the urethra which have been incorporated to the ventral proximal aspect of the cyst. Incision placed at the neck (pointed to by the arrow) will lead to excision of these structures.