CASE REPORTS

Reconstructive Surgery for Female Genital Mutilation Starts Sexual Functioning in Sudanese Woman: A Case Report

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ABSTRACT

Introduction. Female genital mutilation (FGM) involves the partial or complete removal of the external female genitalia and/or other injury to the female genital organs whether for cultural or other nontherapeutic reasons.
Aims. The study aims to describe the method of and findings from reconstructive surgery for FGM victims.
Methods. We present a case of a 24-year-old Sudanese female, who had undergone ritual FGM type III as a young girl. She had suffered from a large, vulval mass for the last 6 years and came to the clinic because of apareunia. We performed mass excision and reconstructive surgery of the mutilated genital tissue.
Results. The giant mass was successfully removed. Remaining genital tissues were approximated and sutured, with hemostasis assured for the reconstructed organs on each side.
Conclusion. Reconstructive surgery for women who suffer sexual consequences from FGM is feasible, with a high degree of client acceptance and satisfaction. It restores some of women's natural genital anatomy, and offers the potential for improved female sexuality. **Fazari ABE, Berg RC, Mohammed WA, Gailii EB, and Elmusharaf K. Reconstructive surgery for female genital mutilation starts sexual functioning in Sudanese woman: A case report. J Sex Med 2013;10:2861–2865.**

Key Words. Female Genital Cutting; Female Genital Mutilation; Reconstructive Surgery; Sexual Functioning; Africa

Introduction

Female genital mutilation (FGM), often referred to as female circumcision or female genital cutting, constitutes all procedures that involve the partial or complete removal of the external female genitalia and/or other injury to the female genital organs whether for cultural or other nontherapeutic reasons [1]. In 2008, to clarify understanding of the prevalence as well as consequences of the practice, the World Health Organization (WHO) introduced the following classification of FGM: Type I (clitoridectomy) consists of the partial or total removal of the clitoris and/or the prepuce. Type II (excision) is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Type III (infibulation) is considered the most invasive type of FGM and involves narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris. Finally, type IV refers to all other harmful procedures to the female genitalia, for example pricking, piercing, incising, scraping, and cauterizing (no genital tissue is excised) [1].

FGM is an ancient tradition that crosses national frontiers, but is primarily practiced in 28 countries in Central and East Africa with the highest prevalences found in Egypt, Ethiopia,

Guinea, Mali, Somalia, and Sudan [2]. It has been estimated that 130–140 million girls and women are affected by FGM and that every year about 3 million more female children are at risk of undergoing the procedure. While most widespread in Africa, the practice also occurs among immigrant communities in North America and Europe [1]. A range of reasons, which differ across regions and cultural groups, exist for FGM, but the practice is generally carried out as a matter of social convention. It is rooted in tradition and beliefs such as the conviction that FGM is a religious requirement, a prerequisite for marriage, and necessary to control women's sexuality [3].

FGM is typically performed on prepubescent girls, often without anaesthetics. It has no known health benefits, whereas the range of physical and psychological complications is beginning to be systematically mapped. According to a WHO literature review, there are both short-term and long-term sequelae, the most common being severe pain, bleeding, difficulty in passing urine and feces, and infections. Inclusion cysts were also commonly reported [4]. With regard to sexual complications, a recent systematic review that included 15 comparative studies showed that women with FGM were more likely than women without FGM to experience pain during intercourse, reduced sexual satisfaction, as well as reduced sexual desire [5].

Nearly all medical professional organizations, led by WHO and the World Medical Association, have condemned FGM and consider it a violation of human rights [1]. Considerable progress in the effort to end FGM has been achieved, and programs' continued prevention effect will eventually reduce the number of girls subjected to the practice. However, while the corresponding need for treatment of complications will be reduced, for years to come, care will be necessary for more than 100 million girls and women living with complications from FGM. Thus, evidence of the management and effectiveness of reconstructive surgery of altered genital anatomy is important to researchers and practicing clinicians, both those living in high FGM endemic areas and increasingly multiethnic societies with growing numbers of women originating from countries where FGM is commonly practiced. Limited data are available with which to assess the operation of reconstructive surgery of mutilated external genital organs, a procedure that aims to restore some of the altered genital anatomy.

Aims

As one of the first, this case report describes the method of and findings from reconstructive surgery for FGM victims.

Methods

We present a case of a 24-year-old Sudanese female, who had undergone ritual FGM type III around age 6. She had suffered from a large, vulval mass for the last 6 years and came to the clinic because of apareunia (no coitus due to the inability to achieve penetration). She had married 3 months earlier and failed penetration caused marital and sexual distress. We performed mass excision and reconstructive surgery of the mutilated genital tissue, with the aim to enable penetration and achieve satisfaction with sexual activity. The study took place at the Academy Charity Teaching Hospital in Khartum, Sudan.

Results

The review of the patient's medical and surgical history was insignificant, and general and systemic examinations revealed normal findings. Local vulval examination revealed a giant mass of 12 cm × 11 cm at the midline. It had smooth, hairless surface, was nontender and freely mobile, and had no skin changes (Figure 1A). By lifting up the mass, a small opening was seen below at the perineum site (Figure 1B). Mass excision was proposed, with the possibility of reconstructive surgery if remaining genital tissues were sufficient to allow for reconstruction. The patient and her husband were counseled and gave consent.

The patient's medical history was carefully reviewed with appropriate examinations. The patient was admitted early morning on the day of surgery. It was scheduled for a week after the patient completed her menstrual cycle, aiming for good hygiene with good low gastrointestinal preparations. Because the surgery was considered a moderate-level surgical procedure, the patient was seen by an anesthetist and the operation performed under low spinal anesthesia. Under optimal aseptic conditions and the patient in lithotomy position, the following steps were performed (illustrated in Figure 2):

1. Identification of the midline of the vulval anatomy from where the dissection would start.
2. Insertion of Folley's catheter, which was challenging because of the narrow, distorted anatomy. The catheter provided good protection for the