When Cultures Collide

Female Genital Cutting and U.S. Obstetric Practice

Leah B. Rosenberg, Keri Gibson, MD, and Joanna F. Shulman, MD

Downloaded from https://journals.lww.com/greenjournal by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC4/OAVpDDa8KKGKV0Ymy+78= on 09/02/2020

CASE: A 28-year-old primigravida at 41 weeks of gestation, previously unregistered, presented to a tertiary care Labor and Delivery unit reporting painful uterine contractions 7 minutes apart. The patient, a recent immigrant from a Northeastern African country, was accompanied by her extended family. She promptly disclosed that as a 10-year-old she underwent genital cutting in her country of origin.

Physical examination revealed the results of Type III female circumcision, or total removal of the clitoris and labia minora, and infibulation, or sewing together, of the labia majora. The prepuce and body of the clitoris were completely absent. In addition, the external urethral orifice was not visible due to extensive scar tissue overlying the infibulation. The scar tissue was pale gray, avascular, and extended almost the entire length of the labia majora, leaving a relatively small opening. As active labor continued, it became clear that the constricted opening would not allow for fetal descent. The obstetrician in attendance subsequently performed a midline episiotomy through the perineal body. A healthy male neonate was delivered. During the postpartum examination, the obstetrician identified extensive lacerations as well as an almost total separation of the previously fused labia majora.

The obstetrician explained the reasoning for midline episiotomy repair to the patient and her sister, who was continuously at the bedside. The obstetrician also informed the patient that the infibulation separated. As the obstetrician began repairing the internal lacerations, the patient insisted that the labia majora be sewed back together (reinfibulation). Although the obstetrician explained the risks of poor wound healing and infection from suturing a devascularized tissue plane, the sister emphasized the importance of infibulation in their culture and the need to have the circumcised anatomy restored. After careful consideration, the obstetrician performed a repair of the lacerated tissue, including a partial reinfibulation.

From the Mount Sinai School of Medicine, New York, New York; University of Utah Hospitals and Clinic, Salt Lake City, Utah; and Department of Obstetrics, Gynecology & Reproductive Science, The Mount Sinai Medical Center, New York, New York.

Ms. Rosenberg is a fourth-year medical student at Mount Sinai School of Medicine who has a strong interest in biomedical ethics.; Dr. Gibson is a fourth year resident in Obstetrics and Gynecology at the University of Utah whose interest in this subject began as a Peace Corps volunteer in Mali.; Dr. Shulman is Assistant Professor of Obstetrics and Gynecology at The Mount Sinai School of Medicine in New York. Over the years she has encountered a few patients who had undergone female genital cutting in their home countries before coming to New York; these women have sparked many passionate discussions of the ethical and patient care issues involved.

Address correspondence to Consultant Editor for Clinical Case Series: Ingrid Nygaard, MD, MS, University of Utah School of Medicine, Department of Obstetrics and Gynecology, 30 North 1900 East, Room 2B200, Salt Lake City, UT 84132; e-mail: ingrid.nygaard@hsc.utah.edu.

Financial Disclosure
The authors did not report any potential conflicts of interest.

© 2009 by The American College of Obstetricians and Gynecologists. Published by Lippincott Williams & Wilkins.
ISSN: 0029-7844/09

QUESTIONS FOR THE COMMENTATOR

What is the prevalence of female genital cutting worldwide?

Female genital cutting, also known as female genital mutilation, circumcision, or ritual cutting, is a traditional practice that is near-universal in certain parts of the world and exceedingly rare in others. The various nomenclature reflect the charged nature of the debate, and for our article, we have selected the term "female genital cutting." The procedure is controversial in both developing nations and the industrialized world. With contemporary migration patterns, many obstetrician–gynecologists in the developed world will care for a woman who has had female genital cutting. Defining female genital cutting as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non medical reasons," the World Health Organization estimates that 100–140 million women worldwide have had some version of female genital cutting or mutilation.[1] In Africa, an estimated 91.5 million women and girls have undergone female genital cutting.[2] Although prevalence varies from an estimated 97.9% of Somalian women ages 18–49 to a low of 0.6% of women in Uganda, growing refugee populations blur the borders of national prevalence statistics. In addition, the World Health Organization

Copyright© American College of Obstetricians and Gynecologists

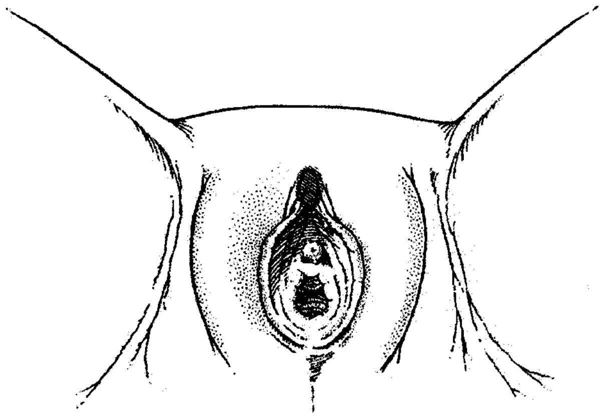

Fig. 1. *Shaded areas* represent the tissue removed in Type I female genital mutilation or circumcision (removal of prepuce and/or clitoris). Toubia N. Female circumcision as a public health issue. N Engl J Med 1994;331:712–6. Copyright © 1994 Massachusetts Medical Society. All rights reserved.
Rosenberg. Female Genital Cutting. Obstet Gynecol 2009.

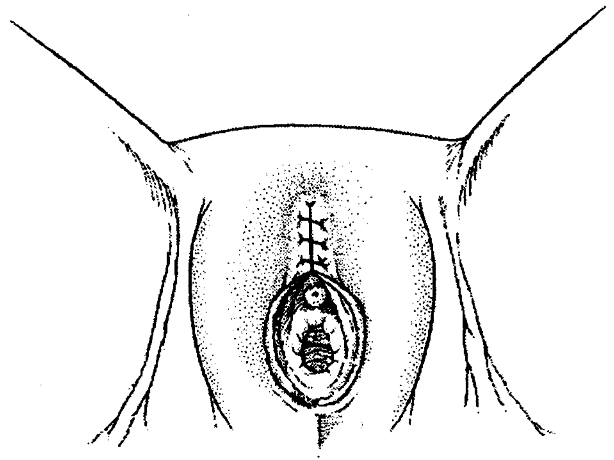

Fig. 2. An example of a repaired clitorodectomy. N Engl J Med 1994;331:712–6. Copyright © 1994 Massachusetts Medical Society. All rights reserved.
Rosenberg. Female Genital Cutting. Obstet Gynecol 2009.

estimates that approximately three million girls are at risk for receiving the practice each year.

Why is female genital cutting performed?

In many cultures where female genital cutting is performed, it is viewed as a rite of passage to adulthood as well as a source of esthetic beauty. The practice is often believed to ensure a woman's virginity and thus her suitability for marriage and subsequent child bearing–a matter of paramount importance for many women in traditional societies. In certain cultures, the clitoris is considered unattractive and dirty and may be viewed as a cause of infection or infertility. Furthermore, the narrowed introitus produced by Type III female genital cutting is believed to increase men's sexual pleasure – although in fact it may prevent vaginal penetration. Female genital cutting has erroneously come to be associated with Islam; however, the practice antedates the Qur'an and has its origins in a variety of tribal settings.[3]

What are the various presentations of female genital cutting?

The World Health Organization classifies female genital cutting into four subtypes, roughly graded by invasiveness of the procedure. Type I (Fig. 1) is confined to clitoridectomy, or the surgical removal of the clitoris and sometimes the prepuce. Type II (Fig. 2) involves a more extensive excision of both the clitoris and labia minora and may involve removal of the labia majora as well. Type III (Fig. 3), the presentation of the case patient, is characterized by the infibulation procedure, where the introitus is narrowed by cutting, repositioning, and sewing the labia majora. In Type III female genital cutting, the clitoris may or may not be removed.[4] Type IV female genital cutting encompasses all other nonmedical procedures such as cutting, pricking, burning, and other modification.[5]

What are the possible medical sequelae of female genital cutting?

The main short-term medical complications of female genital cutting are pain (both from lack of anesthesia

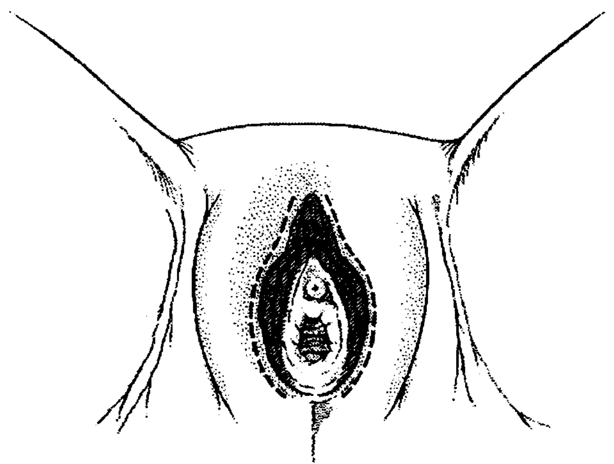

Fig. 3. *Shaded areas* represent the tissue potentially removed in Type III female genital mutilation or circumcision; *dashed lines* represent the skin sewn together in the infibulation portion of the procedure. Toubia N. Female circumcision as a public health issue. Toubia N. Female circumcision as a public health issue. N Engl J Med 1994;331:712–6. Copyright © 1994 Massachusetts Medical Society. All rights reserved.
Rosenberg. Female Genital Cutting. Obstet Gynecol 2009.

Copyright© American College of Obstetricians and Gynecologists

and postoperatively), infection, and bleeding. The practice can spread infection when the procedure is performed using the same unsterilized instruments for many girls in the same village. A localized skin infection can quickly become septicemia in a rural setting without access to antibiotics. Profuse bleeding can occur when the clitoral artery is severed during clitoral excision.

Long-term complications include dysuria, dyspareunia, dysmenorrhea, obstruction of labor, and psychological trauma. Micturition can be impaired because the neointroitus (referring to the opening of the vagina after the girl has undergone infibulation) provides only a small aperture for urinary flow. This can lead to calculus formation and frequent urinary tract infections. Dyspareunia is a common complaint of females who have undergone female genital cutting, and can be exacerbated by keloid formation. Some women seek care for apareunia (the inability to achieve penetration) leading to infertility. After Type III female genital cutting (infibulation), dysmenorrhea is common, related to the restricted menstrual flow. Women with clitoral neuromas and epithelial inclusion cysts after female genital cutting may present with a painful vulvar mass. This experience also may lead to psychological trauma, particularly posttraumatic stress disorder, which may be triggered when the girl reaches sexual maturity and tries to receive a pelvic examination, Pap test, or attempts intercourse.

In the developing world, women with a history of female genital cutting are at higher risk for a prolonged second stage of labor due to obstruction as well as vesicovaginal and rectovaginal fistulae due to pressure of the fetal head on the vaginal wall. At delivery, such women are at risk for a larger volume of blood loss due to less predictable perineal tears.

A prospective study by the World Health Organization of 28 obstetric centers in six African countries reported that Types II and III female genital cutting were associated with higher risks of cesarean delivery, postpartum hemorrhage, and infant resuscitation, and all types of female genital cutting were associated with extended hospital stay and stillbirth compared with those women who had not been circumcised.[5]

What are the relevant issues for the obstetrician–gynecologist of a woman with a history of female genital cutting?

One of the primary objectives for the physician caring for women who have had female genital cutting is to provide a gentle and sensitive examination. Such women often have suffered psychological trauma as a result of this event in their childhood, and a pelvic examination can trigger posttraumatic stress disorder.

It is important to initiate conversations with pregnant patients about these issues early in antenatal care. The obstetrician should understand the type of circumcision and the differences in gynecologic structure and function. The American College of Obstetricians and Gynecologists (ACOG) guidelines for healthcare recommend offering defibulation (taking down the original infibulation) during the second trimester under spinal anesthesia.[6] In a recent study, Nour et al[4] found that antepartum defibulation greatly reduced the associated risks as well as exposed the patient's clitoris in 46% of cases. Taking this into consideration, it is important to thoroughly discuss the patient's expectations. The alteration (even if it is restoration) of a woman's genital anatomy from the way it has been since puberty may generate a strong emotional response. Furthermore, many women with female genital cutting have limited knowledge regarding the structure and function of their external genitalia. A sensitive approach to patient education is an essential component of their care. Obstetricians should also counsel women who undergo defibulation that their menstrual flow and stream of urine will change after the procedure. While some women will request restoration of their anatomy to the state before female genital cutting, other women strongly desire reinfibulation after delivery (discussed further below). Documentation of the particular type of circumcision (ie, Type II, etc) and a clear written communication of the patient's wishes is necessary in the context of a group practice.

What is the position of the American College of Obstetricians and Gynecologists on female genital cutting and patient requests for reinfibulation?

American College of Obstetricians and Gynecologists Committee Opinion Number 151, published in January of 1995, states that ACOG "joins many other organizations in opposing all forms of medically unnecessary surgical modification of the female genitalia."[7] The statement emphasizes the importance of raising awareness about the issue and treating female genital cutting patients with sensitivity and culturally competent care. In addition, ACOG recommends that practitioners caring for women with female genital cutting apprise themselves of alternative methods of obstetric and gynecologic procedures to accommodate the results of the procedure. With regard to "specialized care of the patient who has undergone female genital cutting," ACOG specifically mentions

Copyright© American College of Obstetricians and Gynecologists

the need for scarring revision and defibulation among other potentially relevant surgical procedures but does not remark upon cases where reinfibulation is requested.

Should an obstetrician–gynecologist participate in the primary procedure or postpartum repair of female genital cutting?

According to federal criminal law,[8] it is illegal for any physician or person in the United States to perform female genital cutting on a girl aged younger than 18 years. In addition, a 2002 decision by the Federal Court of Appeals for the 7th Circuit classified female genital cutting/mutilation as a form of torture sufficient to grant asylum status.[9] This law allows a degree of ambiguity surrounding the reinfibulation of women aged older than 18 years. For this reason, physicians must find a culturally appropriate solution that satisfies the demands of professional ethics. The ethical tension in the case concerns the competing principles of beneficence and respect for patient autonomy. While physicians are rightfully committed to "doing good" for patients, this case involves a complex request originating in the intimate matrix of culture and sexuality.

If postpartum reinfibulation of an adult patient can be viewed as a cosmetic procedure analogous to a vaginoplasty or clitoral/labial tattoo, it might seem inconsistent to forbid physician participation. In addition, some critics of U.S. and Canadian anti–female genital cutting legislation have argued that criminalizing female genital cutting as a "special case" procedure can be viewed as a type of cultural imperialism. Pragmatically speaking, it is possible that physician nonparticipation will lead to women seeking out providers to perform the procedure in a community setting without the benefit of antiseptic technique. However, physician performance of reinfibulation seems to run counter to national and international guidelines on the primary procedure of female genital cutting. There is a need for an expanded discussion among American obstetrician–gynecologists as well as their regulatory bodies on the establishment of a consensus regarding postpartum reinfibulation.

REFERENCES

1. World Health Organization. Eliminating female genital mutilation: an interagency statement. Geneva (Switzerland): WHO Press; 2008.
2. Yoder PS, Khan S. Numbers of women circumcised in Africa: the production of a total. Calverton, Macro International Inc. MEASURE DHS, 2008 Mar. 19 p. (DHS Working Papers No. 39USAID Contract No. GPO-C-00-03-00002-00).
3. American College of Obstetricians and Gynecologists. Female genital cutting: clinical management of circumcised women. 2nd ed. Washington (DC): ACOG; 2007. p. 10.
4. Nour NM, Michels KB, Bryant AE. Defibulation to treat female genital cutting: effect on symptoms and sexual function. Obstet Gynecol 2006;108:55–60.
5. World Health Organization. Fact Sheet Number 241. May 2008. Female genital mutilation. Available at: http://www.who.int/mediacentre/factsheets/fs241/en. Retrieved August 24, 2008.
6. American College of Obstetrics and Gynecology. Guidelines for women's health care. 3rd ed. Washington (DC): ACOG; 2007. p. 243–7.
7. ACOG committee opinion. Female genital mutilation. Number 151–January 1995. Committee on Gynecologic Practice. Committee on International Affairs. American College of Obstetricians and Gynecologists. Int J Gynaecol Obstet 1995; 49:209.
8. 18 U.S.C. § 116 [Federal Criminal Code].
9. Nwaokolo v. Immigration and Nationalization Service, 314 F. 3d 303 (7th Cir. 2002).

OBSTETRICS & GYNECOLOGY

In The Trenches

Practical Case Series

The Green Journal welcomes submissions of cases for the "In the Trenches" series. Cases (300 word maximum) considered by the Editors to illustrate clinical issues that are especially prevalent, challenging in women, and of high educational value will be chosen for potential publication. Case authors will work with the series editor to identify commentators. For more detailed information about "In the Trenches" requirements for authors, please see our web site (www.greenjournal.org). For questions, please contact Ingrid Nygaard, Clinical Case Series Editor, at ingrid.nygaard@hsc.utah.edu.

Let Us Hear From You

rev 10/2008

Copyright© American College of Obstetricians and Gynecologists