

CASE REPORT

Female genital mutilation/cutting type IV in Cambodia: a case report

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Funding Information

No sources of funding were declared for this study.

Received: 3 June 2015; Revised: 24 July 2015; Accepted: 30 August 2015

Clinical Case Reports 2015; 3(12): 979–982

doi: 10.1002/ccr3.403

Introduction

According to the World Health Organization (WHO), female genital mutilation (FGM), also called female genital mutilation/cutting (FGM/C) or female genital cutting (FGM/C) is any procedure involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons. This practice is prevalent in Eastern and Western Africa, among some ethnic groups in Indonesia, Malaysia, and areas of the Persian Gulf, and in the Western world due to migration. WHO defines four types of FGM/C. Type IV includes all harmful procedures for nonmedical purposes not included as type I, II, or III, such as pricking, piercing, incising, scraping, and cauterization. FGM/C violates the human rights of women and girls, has no health benefits, and can have significant, negative, psychophysical health outcomes as well as health costs [1].

Medicalization of FGM/C refers to situations in which FGM/C is practiced by any category of healthcare provider, in a public or a private clinic, at home or elsewhere. It also includes reinfibulation at any point of time in a woman's life. Medicalization of FGM/C has been condemned by WHO and medical associations including the

Key Clinical Message

Nontherapeutic female genital modifications can cause short- and long-term consequences. Caregivers should promote women's self knowledge on genitals' anatomy and physiology, and psychophysical and sexual health. They should also inform on possible negative consequences of vulvar nontherapeutic alterations requested and avoid the medicalization of female genital mutilation.

Keywords

Female genital mutilation, female genital cutting, female genital mutilation/cutting, FGM Type IV, FGM/C type IV, female genital cosmetic surgeries.

International Federation of Gynecology and Obstetrics (FIGO), United Nations agencies, international agencies, nongovernmental organizations (NGOs), and governments [2].

In spite of the differences in terms of age and consent, unsolved controversies exist about the fact that some female genital cosmetic surgeries (FGCS) can resemble in terms of definition, technique, and final result to some FGM/C [3–5]. Some have advocated that FGCS could be included among FGM/C type IV [6]; others have drawn parallels in terms of cultural and social pressures leading women and girls to ask for female genital modifications, which can be named FGM/C or FGCS according to the socio-cultural setting in different regions of the world [7].

FGCS are defined as a variety of corrective genital procedures without medical indication and include labiaplasty, clitoral hood size reduction, clitoridectomy, perineoplasty, vaginoplasty, hymenoplasty, G-spot augmentation, “vaginal rejuvenation” [8]. Cosmetic clitoral hood reduction, clitoridectomy [9], and labia minora reduction are, from an anatomic point of view, the same procedures as FGM/C type I and II. However, if an African woman asks for her own or her adolescent daughter's genitals to be excised for traditional reasons, it is a crimi-

nal offence. Yet, if a woman or a girl thinks her own genitals are abnormal in shape or size, the surgery is provided [10]. The controversy is also due to the fact that the FGM/C definition does not specify that these are ritual procedures and differ from FGCS, which are cosmetic [3]. The contradiction in some countries is also due to the legislation against FGM/C, which does not make distinction between adults and minors and motives [4, 5].

Another controversial parallelism is between FGCS and reinfibulation. Reinfibulation is the resuturing in any moment, of the incised scar tissue resulting from infibulation [11], not recommended by FIGO and WHO [11]. Some authors and countries such as the United States, consider that an adult, informed, autonomous woman asking for reinfibulation is to be considered as an adult, autonomous woman asking for FGCS. Therefore, reinfibulation is allowed [1, 11]. On the contrary, in other countries such as the United Kingdom, reinfibulation is illegal [12].

We present the case of a woman having voluntarily undergone a nontherapeutic vulvar surgery in her own country, Cambodia, for socio-cultural reasons. Our aim is to report a new form of FGM/C type IV, performed by a surgeon in a country where FGM/C have never been reported before; to present the management and counseling of our patient, and to discuss the definition of FGCS, FGM/C, medicalization, and autonomous and informed consent to these practices.

Case history/examination

A 32-year-old gravida2 para1 woman from Cambodia consulted at our hospital during the third trimester of pregnancy. She had arrived in Switzerland few months before. Family and personal history revealed a chronic HBV infection, a spontaneous uneventful pregnancy, and delivery with a different partner in 2002 in Cambodia, at the hospital. The woman had undergone a vulvar surgery

in a private clinic in 2010 after the separation from his first partner, to narrow her vulva and find a new partner more easily. She had consulted a private clinic with a slightly older friend, and they both had had the vulvar surgery by a certified surgeon, under local anesthesia. She explained us that different narrowing vulvar surgeries are available in Thailand, Cambodia, and Singapore to make the vulva narrower after having had children and separated from the partner. It is believed that this helps to find a new husband more easily. She also explained us that depending on the money a woman has to spend on it, she can choose different vulvar surgeries. The best ones she had heard about were in Singapore. As she did not have much money to travel at that time, she had opted for a “simple” vulvar surgery under local anesthesia in her country, Cambodia. No man had asked her to undergo it. She had only discussed it with female friends. Vulvar inspection revealed a sort of inferior infibulation (Figs 1 and 2). According to WHO, FGM/C type III, also called infibulation, corresponds to the narrowing of the vaginal orifice with the creation of a covering seal by the apposition of the labia minora or majora [1]. In FGM/C type III, the apposition of the labia starts superiorly and covers the urethral meatus and part of the vaginal orifice. In the case we present, the labia minora had been stitched inferiorly along about 2 cm from the fourchette. We classified this form of female genital alteration as FGM/C type IV [1]. The patient reported no present sexual problems such as superficial dyspareunia. Her present partner was also from Cambodia, had been living in Switzerland for a longer time and found her vulvar appearance atypical but fine.

Differential diagnosis, investigations, and treatment

We discussed with the woman and her husband an inferior intrapartum defibulation to avoid vulvar and perineal tears. Defibulation is a surgery that consists in exposing



Figure 1 – 5. (1) and (2) External genitalia with FGM/C type IV. The labia minora are stitched together on about 2 cm from the fourchette making the vaginal orifice narrower. (3) and (4) Intrapartum inferior defibulation. (5) Vulvar appearance at 6 weeks postpartum.

the vaginal orifice and urethral meatus in FGM/C type III [13]. In our case, instead of exposing the superior part of the vaginal orifice, we exposed the inferior part. We explained to the woman and his husband that the inferior defibulation would allow to remove the bridge of skin created by the stitching of the labia minora, allowing the physiologic progression of the fetal head and avoiding tears. We followed the national and international recommendations on avoiding restitching [1, 11, 14, 15] and explained to the woman that we would have restored her normal genital anatomy and physiology avoiding a new defibulation in case of a third delivery. We also reassured our patient that if she would not be satisfied with her further genital appearance, we could discuss about eventual surgeries afterwards. The woman's counseling included drawings and pictures of the female genitalia and perineum, and information on postpartum pelvic floor training (manual perineal re-education; biofeedback; etc.).

The woman and her husband agreed with our proposals and accepted a no restitching.

Outcome and follow-up

She delivered vaginally at term without any fetomaternal complications and with no perineal tear after inferior defibulation was performed during the first stage of labor (Fig. 3), under loco regional anesthesia. The labia minora were reconstructed with simple separated stitches of Vycril 3.0, Ethicon (Fig. 4). Delivery and postpartum follow-up were uneventful.

At the 6 weeks postpartum check-up, the woman, reported to be very satisfied with the care and follow-up received, and with the new genitals' appearance (Fig. 5). She had restarted sexual intercourses with no pain. She also underwent postpartum pelvic floor training.

Discussion

We report a new form of female genital nontherapeutic surgical procedure, requested and performed for socio-cultural reasons in an adult consenting woman. According to the definition of WHO [1], this could be classified as FGM/C type IV. The inferior stitching of labia minora has never been reported before in the literature. The procedure was performed by a certified surgeon in a private clinic and under local anesthesia, in a country not included among those where FGM/C are traditionally documented. Cambodia has never been mentioned as a country at risk of FGM/C, differently from Malaysia and Indonesia. FGM/C were documented in Eastern and Western Africa, Indonesia, Malaysia; areas of the Persian Gulf, and the Western world due to migration [1]. Some authors have anecdotally documented the

practice in other countries such as India [16], Sri Lanka, Peru [1], Colombia [17], Democratic Republic of Congo, Oman [1], and United Arab Emirates [18]. Further studies could evaluate the prevalence, types, performers, motivations, and consequences of nontherapeutic genital modifications in South East Asia as data is lacking.

The reasons for undergoing the surgery advocated by the woman were socio-cultural. The narrowing of the vaginal introitus was seen as a way to find a new partner more easily after having had a child with a previous man. She did not undergo it for virginity repair, aesthetic reasons, or genitals' beautification. She reported having had information on female genitalia and the surgery only by other women and friends. She was not aware of possible complications. Social pressure, social acceptance, false beliefs, and in particular the belief of enhancing the own genitalia for a partner [11, 19], are reasons explaining the persistence of FGM/C [1]. A recent review mentioned that FGM/C type IV is generally practiced on mature age groups, with knowledge and consent [20], and it has been pointed out that adult women should be free to choose what make them happy with their body [7]. However, to freely choose what make them happy, women should be informed, understand the information received, and the consequences of their choices. They have also to feel free to have their genitalia how they want instead of how they think they would help them finding a partner.

FGM/C type IV can cause short- and long-term consequences that vary depending on the subtype [20]. The new form we report could lead to similar complications as FGM/C type III including scarring problems, stagnation of the urine or menstrual blood behind the scar, superficial dyspareunia, obstructed delivery, increased risk of tears and episiotomy, need of defibulation, and difficult gynecological examinations.

Gynecologists, pediatricians, plastic surgeons, and other caregivers, should offer correct information to women, girls, and their partners to promote their self knowledge on genitals' anatomy and physiology, and on psychophysical and sexual health. They should also inform on possible negative consequences of vulvar nontherapeutic alterations requested and avoid the medicalization of FGM/C.

Patient Informed Consent

A patient informed written consent was obtained before publishing the case.

Acknowledgments

None.

Disclosure of interest

None declared.

Contribution to authorship

JA, OI, BMT: conception and planning, carrying out, analyzing and writing up, revision and final approval.

Details of ethics approval

N/A.

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