

Surgical Techniques

Surgical Techniques: Defibulation of Type III Female Genital Cutting

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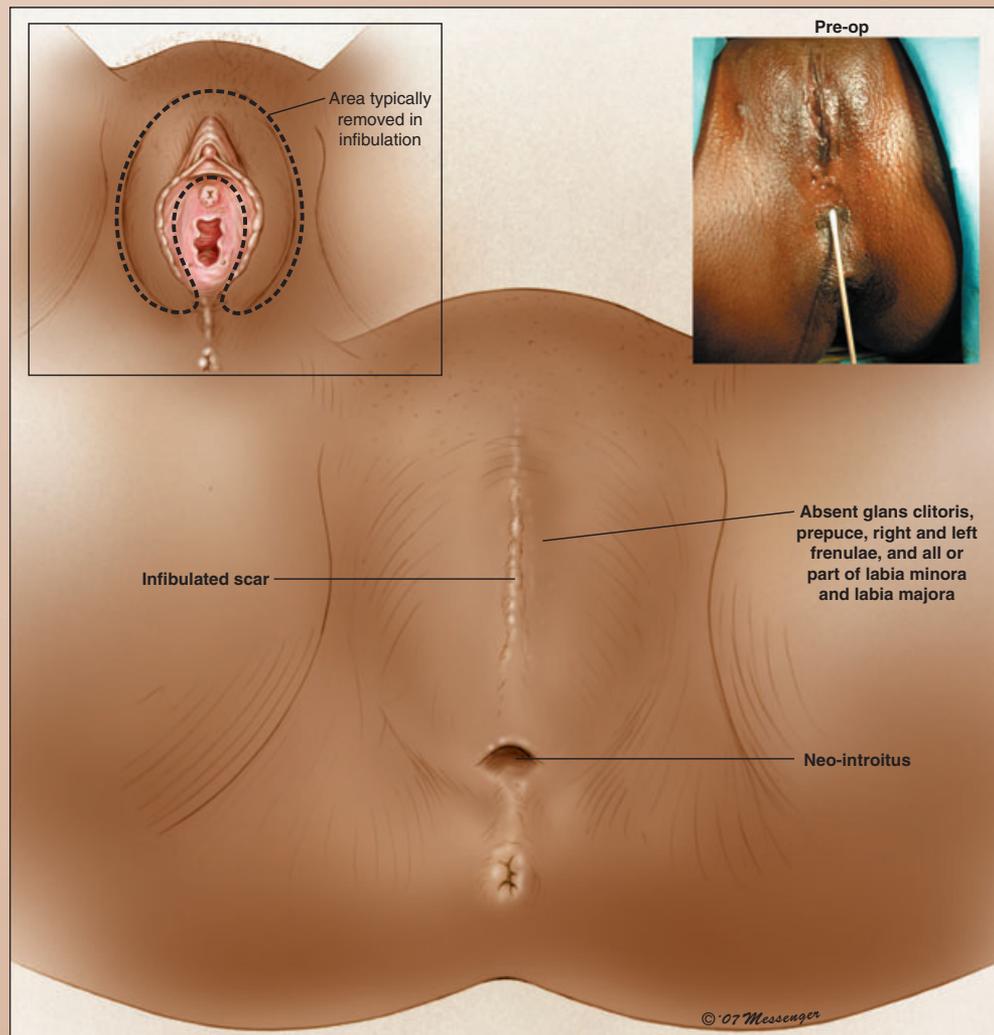


FIGURE 1

Female genital cutting (FGC) is a tradition practiced in parts of Africa, Middle East and Asia. Type III FGC, also known as infibulation, involves removing part or all of the external genitalia, generally, the prepuce, clitoris, labia minora, and majora. The remnant raw surfaces are sutured together (infibulated) using catgut sutures, thorns, or other adhesive concoctions to cover the urethra and most of the vagina. A stick is introduced in the posterior incision to guarantee a small opening (neo-introitus) for the passage of urine and menses. The girl's legs are bound together for 1–2 weeks on bed rest with minimal oral intake to minimize urination and defecation in order to facilitate wound healing. Women who have undergone FGC can suffer immediate and long-term complications. Immediate complications include bleeding, hemorrhage, infection, sepsis, and death. Long-term complications include dysmenorrhea, dyspareunia, infertility, chronic vaginal, and urinary tract infections.

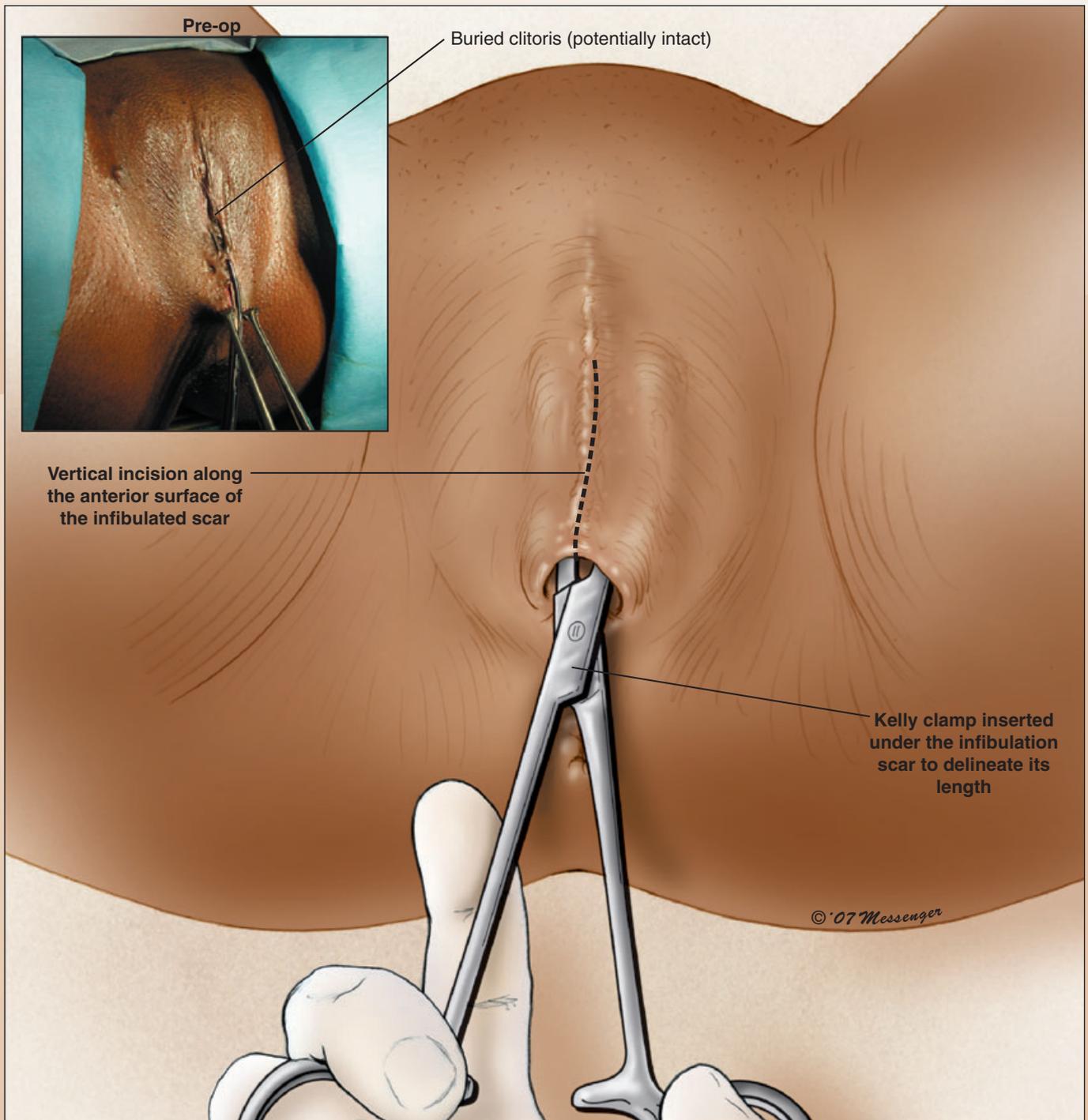


FIGURE 2

Physicians are increasingly seeing infibulated women and are learning how to provide them with optimal medical and surgical care. Defibulation is a procedure that releases the vulvar scar tissue, exposes the introitus, and creates new labia majora. Defibulation is recommended for infibulated women who suffer complications or are pregnant. It reduces symptoms, improves sexual function, and eases vaginal deliveries. Surgery can be performed under general or regional anesthesia. Local anesthesia should be avoided as patients may experience posttraumatic stress disorder (PTSD). Pregnant women should be defibulated during their second trimester under regional anesthesia. Prior to starting, the clitoral region should first be palpated to assess whether an intact clitoris is buried beneath the scar. A Kelly clamp (Pilling, Research Triangle Park, NC, USA) should be placed in the neo-introitus to delineate the length of scar. Two Allis clamps (Pilling, Research Triangle Park, NC, USA) are placed at two and ten o'clock, and a vertical incision is made anteriorly with Mayo scissors (Pilling, Research Triangle Park, NC, USA) to expose the introitus and urethral meatus.

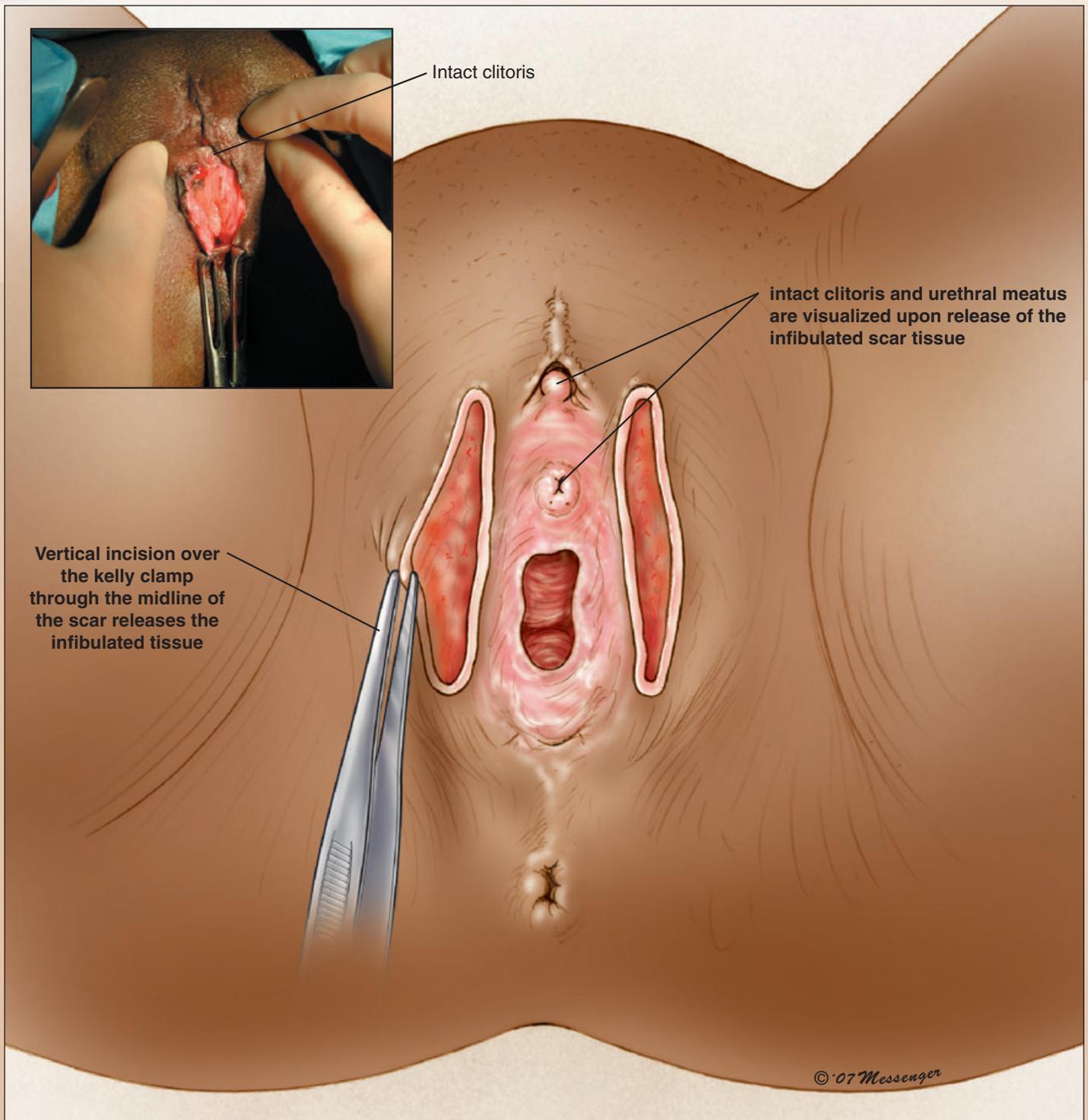


FIGURE 3

Great care should be taken not to injure any clitoral tissue during this process. In one study, 48% of cases had an intact buried clitoris as is seen in this figure [1].

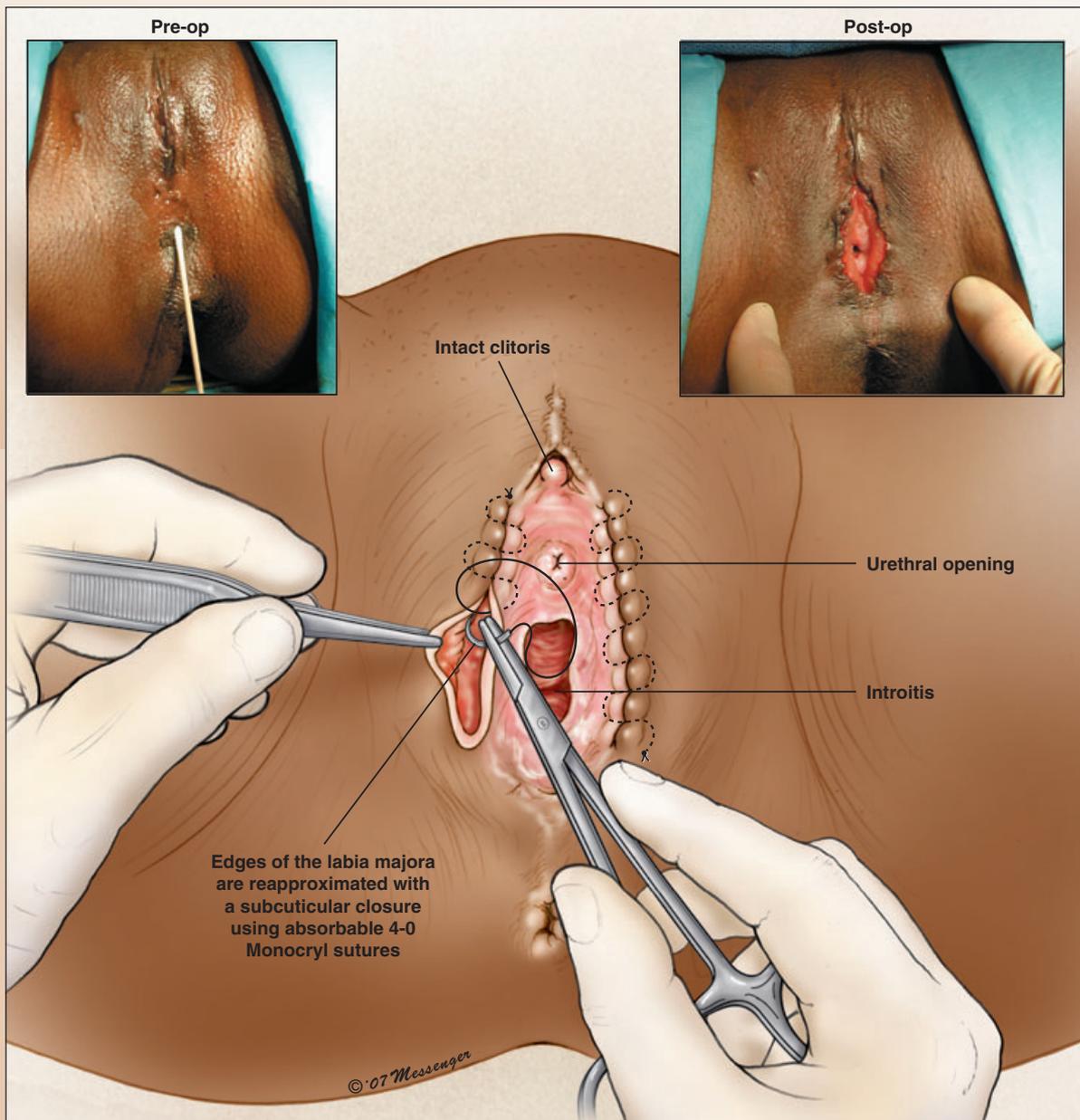


FIGURE 4

The raw edges of the labia majora are then reapproximated with absorbable 4.0 monocryl sutures (Ethicon, Somerville, NJ, USA) in a subcuticular fashion. This prevents the two exposed edges from rehealing together. Long-acting local anesthesia should be injected to ease with postoperative pain. Patients are discharged with oral analgesics and are instructed to perform sitz baths three times a day. They should be made aware that their voiding stream will change and that they should avoid coital sexual activity. The operative site should completely heal by 6 weeks. Of note, Type I female genital cutting (FGC) (clitoridectomy) and Type II FGC (clitoridectomy and partial or total removal of the labia minora) do not require defibulation.

Reference

- 1 Nour NM, Michels KB, Bryant AE. Defibulation to treat female genital cutting: Effect on symptoms and sexual function. *Obstet Gynecol* 2006;108:55–60.