INFIBULATION COMPLICATION AND REPARATORY OPERATIONS

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SUMMARY

In this work the problem of infibulation in female infants in many parts of the world, with particular regard to some african countries, is discussed.

A brief review of the infibulation's origin and its social implications, is given.

Attention is paid to both physical and psychological complications.

Seventeen cases of infibulated women, successfully operated by the Authors for surgical plastics of disinfibulation, are discussed.

The purpose of this study is to discuss some aspects of female circumcision in some parts of Africa (particolarly in East and North Africa). On this subjects, however, there has been a considerable confusion in terminology. In literature many terms are used to indicate the same subject, while one term is also used to express different practices or customs, for esample, incision, circumcision and similar terms are used indiscriminately to describe different types of mutilation of female genital organs.

TYPES OF CIRCUMCISION

1) *Sunna Circumcision* is the operation reccomended by ISLAM and it consists the entire excision of the prepuce of the clitoris.

2) *Simple Excision,* in this operation the clitoris is removed with or without parts of Labia Minora ([3]).

3) *Infibulation*, consists of excision of the clitoris and the Labia Minora and obliteration of the introitus.

The word Infibulation derives from the latin word « Fibula » and refers to the means by which the Romans used to fix the prepuce to re-enforce and maintain chastity; therefore the term infibulation should be used only to describe an operation of the female genital organ such as to obtain a complete closure of the vulva-vaginal vestibule with exeception of a small meatus ([1]); this is the type of operation that is popular in the Sudan ([3]) and in Somalia.

Circumcision is a term which should be reserved for some type of operation of male's genital organ.

The operation is usually referred to as pharaonic circumcision although there is no evidence from predynastic or later mummies that it was carried out during this period of Egyptian history. However some greek papyrus in the British museum dated 163 B. C. refers to the operation as

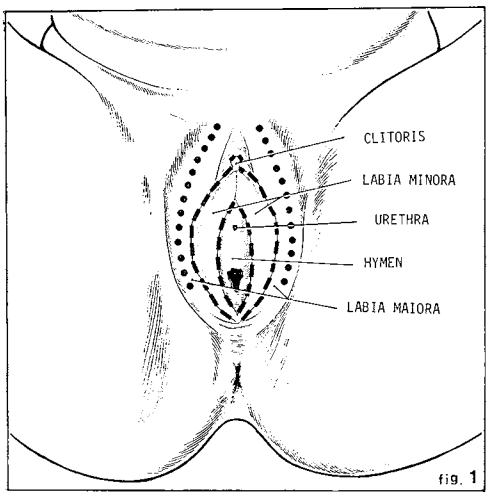

Fig. 1. — The hyphoned area show zones that are removed. The dotted lines shown. The grased area for uniting the two labia maiora.

being performed on girls of Menphis at the age when they received their dowries.

Infibulation or some other female circumcision is performed in many part of the world: in Egypt (until recently), the Somalia, Sudan, Kenya, Ethiopia, Indonesia, Malaya, Eastern Mexico, Peru, Western Brazil and in Russia among the skopizy people ([2, 3]).

RELIGIOUS AND CULTURAL IMPLICATIONS

The purpose of female circumcision is likewise to ensure verginity and as a means of attenuting sexual desire, and tradition has been the main factor in perpetuating the custom, and it had succeded in many societies in makin it immoral for a girl if she is not infibulated; in fact no norman would marry an uncircumcised female.

The beliefs that the female circumcision has Moslem religious background have no true pattern. As a matter of fact the operation had been performed long before Islam and in countries which the Moslem Religion did not even reach. Furthemore it is not practised in many Moslem countries such as Hedjaz, Syria, Yemen, Iraq, Tunisia, Iran and Turkey.

On the other hand in Moslem Countries where it is performed the operation of choice is infibulation and not the Sunna Type reccommended by Islam.

Female circumcision is not mentioned in the Koran, although, according to Ibn Awas the Prophet Mohamed reccomended circumcision as « an ordinance for men and dignified for women ».

And also it is reported that the Prophet said to a woman performing the operation « circumcise, but do not go deep; this is more illuminating to the fate and more enjoyable to the husband and wife ».

This and similar evidence makes it clear that the infibulation is regarded as a social custom but not as an obligation in Islam.

INFIBULATION TECHNIC

In some African countries little girls are infibulated before puberty at an age between 5 and 8 years (or between 5 and

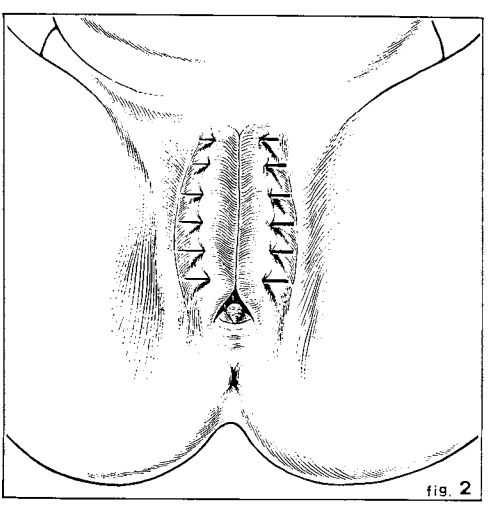

Fig. 2. — Infibulation just completed with the wires that unit the two labia maiora shown.

10 years in families in rural areas). The operation is done at home usually by a « mid-wife ». Other neighbouring women are also invited to witness the operation as a ceremony but men are rigourously excluded.

At present in urban areas, this operation is carried out by medical doctors in hospitals.

The vulva-vagina zone is washed with cold water and covered with MAL-MAL powder (powdered resin with haemostatic and healing effects on wounds used in Somalia).

The operation lasts about 30 minutes.

After the operation the little girl is put on bed with her legs tied with pieces of cloth or with some threads and she should

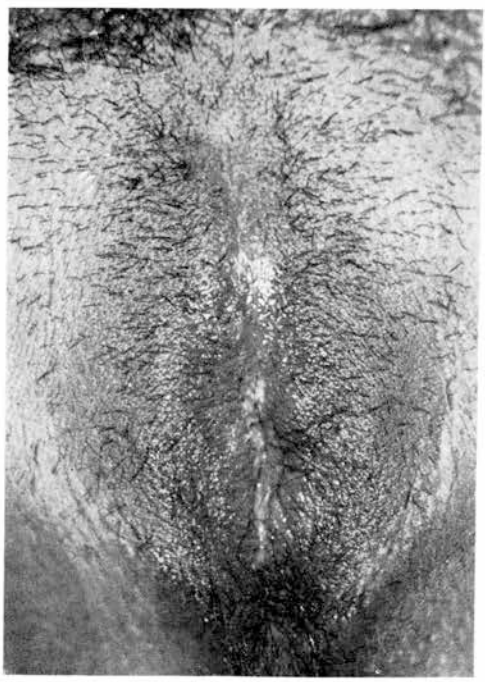

Fig. 3 — Infibulation sequelae.

Fig. 4. — The same case after vulvar recostruction.

The girl is secured in the lithotomy position by eldery women, relatives and friends. The clitoris and its prepuce and in some cases both Labia Minora are cut leaving the injured zone bleeding profusely. Then about three quartees of the labbia majora by its upper section and some milimeter of the mucous edge of about 1 cm wide is scrapped bilaterally; these crapped surfaces are brought together by tightening both labbia majora with thornpin.

remain on bed for the following three days. After about two weeks the wound heals by primary intention.

And as a result the introitus is obliterated by a drum of skin extending across the vaginal orifice, except for a small hole for urinary and mestrual excretion.

COMPLICATION OF INFIBULATION

Immediate complication consist of haemorrhage which can be fatal of the peri-

neal branches of the external pudendal artery and the dorsal artery of the clitoris, neurogenic shock when analgesia is not given, injuries to urethra, bladder and vagina occurs often. Ritension of urine by riflective effect can be provokeid immediately after operation. Anaemia may follow profuse bleeding.

Infection.

Fatal cases of tetanus and septicaemia have been reported. Infection of urinary tract (urethritis, cystitis, abscess) which can lead up to acute or cronic pyelonephritis are common.

Retension of urine caused by urethral tightening or by closure of the external meatus by the edge of the flap skin after scaring abscess of Bartolin glands.

Late gynaecological complication.

20 to 25 % of the cases of infertility in the Sudan are due to infibulation, which may cause chronic pelvic infection or may prevent sexual intercourse ([3]).

Dysmenorrhoea due to chronic pelvic infection or obstruction of the menstrual flow which may lead to haematocolpos or haematometra. Epidermoid cystis are often seen in Sudan according to Mustafa. It is caused by inversion of the skin edges during the healing or by growth of a buried Island of skin detached during the operation. Vaginal calcoli (Laf-Gury) are common in Somalia which are mainly caused by the organization of the powder granules of the mal-mal which are not sufficiently fine.

Lateness in the establishment of menarche.

Psycologic complication.

One fact fundermentally frequent is, in any case, represented by psycologic complication and the repercussion both on individual level and also on social progress.

The first operation for the closure of the vulva is normally followed by a second operation to open it at the period of marriage; at times however the process of di-infibulation can come about with the first sexual intercourse only.

This second operation is more difficult and more painful, for which most young girls, after their first attempt of sexual experience are so traumatised both physically and psychologically that very often it is observed the abandonment of nunctial thalamus or refusal of any sexual intercourse.

Obstetric complication.

As for obstetric complications according to Mustafa, the infibulated expectant mother cannot deliver alone without help. In Sudan and Somalia where many of the population are normads, it may be difficult to have any trained assistant during labour and this would result in very extensive consequencies: perineal lacerations with haemorrhage and infection are very common; besides, very frequent are mechanical dystocia of the perineal zone when the head of the fetus becomes imprisoned in this tight vaginal ostium, which is often followed by atony of the uterus or grave lacerations (up to the 4th grade with the formation of recto-vaginal fistula).

As can also be understood, even where it is possible to obtain the assistance of experts, very extensive episiotomy, to cut through the consequent scar of infibulation, becomes very necessary in all patients.

Casuistry.

In the clinics of Obstetric and Gynaecology of the University of Padova — Verona Branch — ten cases were admitted between 1972 and 1974 and in Padova from 1975 till the time of this publication, 4 cases were also admitted all for the consequencies of infibulation.

The patients are between 20 and 28 years of age.

One of these had pyelonephritis consequent to chronic cyst-urethritis; two were suffering from depressive psychosis, one of which was very frequently subjected to hysteric attacks in correspondance with the menstrual period.

It is to be observed that this symptom could not obviously be refered to as normal menstrual disturbance since the patient never accused any dysmenorrhoic disorder such as to be able to justify her situation. And, in fact these patients had been interned in some Neuropsichiatric Institute without any good results for their illness.

Two cases had presented suppurative Bartolinitis, while four others were admitted simply for the minimum consequencies of infibulation, that is, very grave symptoms of oligomenorrhea — with difficulty in the outflow of menstrual bleeding. Very common in all the patients however were urethritis and cystitis. One primipara had very serious lacerations during delivery, with recto-vaginal fistules, therefore on this patient, a part from the normal recto-vaginal plastics, vulva plastics was also carried out to widen the vaginal orifice which, notwithstanding her marital experience and parity, still remained narrow and with urethral ostium completely covered by adherent labbia majora. As already mentioned, four patients were admitted in our clinics in Padova from 1975 till this publication, of which one was without serious disturbances while another suffered very grave oligomenorrhea and the others had suppurative Bartolinitis.

On one of these, apart from the normal vulva plastics, a transplantation of dermo-epidermoid of the vulva was performed.

All these 14 patients had vulva plastics operations to widen the vulva ostium (vestibulum). In all the cases a satisfactory remission of the symptomatology has been obtained. Exceptionally surprising was the involution of the psychic disturbances of the two cases mentioned above, after five to six months from the operations, obviously with the help and assistance of neuropsichiatrics.

The patient that had had recto-vaginal fistule was pregnant again, one year after the operation, reaching full-term and without any complications both during labour and during a normal delivery.

Operation technic.

The operation technic of vulva-plastics for the consequences of previous infibulation which we carried out, is very simple with good and sure results so far.

Curved Klemmer forceps are introduced between the adherent labbia majora and the vulva-vistibule, raising it so as not to injure the underlying tissues during the incision; a cut is made with a pair of cisors or a lancet across the gutter-zone of the scar formed from the infibulation operation, up to the root of the clitoris thereby freeing the urethral ostium.

This is then followed by single point suture with absordable light thread along the adges of each of the injured labbia majora. In this way attempt is made to riconstruct as much as possible the vulva-vaginal vestibule and the labbia majora, hence to obtain both in size, dimension and configuration the external genital organs more or less normal in their aspects, with the exception obviously of the clitoris which was amputated during the infibulation.

No complications of any kind has been observed during our own experience so far.

CONCLUSION

This work has been intended therefore to demonstrate how vulva plastics, with a simple technic of surgical disinfibulation can save young women, who had previously been subjected to the mutilation of

infibulation, from neuropsychiatric traumas and from other organic complications associated with such pratice, thereby allowing them to face life, especially marital life, with more serenity, less danger to themselves and to the fetus during their pregnant and maternity periods.

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