Female genital mutilation and modification : providing sensitive and appropriate care.

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Female genital mutilation and modification: providing sensitive and appropriate care

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Awareness and recognition of the variability in the practice and therefore consequences of female genital cutting is essential to ensure sensitive and nonjudgmental care is provided, as well as the appropriate referral of patients with long-term complications.

It is also likely that GPs will be increasingly asked to provide advice or to refer women requesting genital cosmetic surgery. GPs are well placed to allay women's anxiety about the appearance of their labial to prevent unnecessary surgical intervention in those with normal genitalia.

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Female genital mutilation, also referred to as female genital cutting (FGC), refers to the practice of partial or total removal of the external female genitalia for nonmedical reasons. The World Health Organization (WHO) estimates that between 100 and 140 million girls and women have undergone FGC and are living with its consequences.[1] FGC is culturally based and is practised by people from a number of religious backgrounds. FGC is not practised universally by any religious group.[2] High prevalence countries include those in western, eastern and northeast Africa, as well as some Asian and middle eastern countries.[3]

GPs are increasingly likely to see women who have experienced FGC as rising numbers of migrants settle in Australia from countries where this traditional cultural practice is prevalent. Although women may present for specialised care related to the long-term complications of FGC, it is more likely that GPs will encounter FGC during a routine consultation for a Pap test or other reproductive and sexual health issues requiring a genital examination. It is important to be aware of the wide variability of the practice and the long-term effects of FGC to provide appropriate care that is sensitive, is nonjudgmental and promotes dignity.

As well as seeing women who have experienced FGC, usually performed at an age before personal consent can be provided, GPs can also expect to see increasing numbers of women

requesting genital cosmetic surgery, in particular labial reduction surgery, for nonmedical purposes. Although the prevalence is unknown in Australia, the fivefold increase in labiaplasty procedures performed through the National Health Service in the UK in the past five years is likely to be replicated here in Australia as elsewhere in the world.[4] More than 5000 enquiries for cosmetic gynaecology were received by the London-based Harley Medical Group private practice, UK, in 2010, 65% of which were for labiaplasty.[5]

The GP plays a vital role in providing an expert and balanced view of the range of normal labial variability and has an ethical responsibility in relation to referral of women for genital surgery for nonmedical reasons. Although the traditional cultural practice of FGC is illegal in Australia as it is elsewhere in the world, the boundaries between this criminal act and procedures involved in female genital cosmetic surgery in consenting adult women are blurred.[6]

This article aims to inform the role of the GP in relation to both the provision of care for women living with the consequences of FGC and in the management of referral requests for female genital cosmetic surgery.

FEMALE GENITAL CUTTING AND ITS CONSEQUENCES

FGC is a traditional cultural practice that has no medical benefits and is practised in communities for a variety of cultural, religious and social reasons. The practice of FGC is a crime in all Australian states and territories, and criminal charges have recently been brought against four people allegedly involved in performing FGC on two girls, aged 6 and 7 years, in New South Wales.[7] The excision, infibulation or mutilation of the whole or any part of the labia minora, labia majora or clitoris of another person is illegal, as is aiding, abetting, counselling or procuring a person to perform these acts.

As healthcare providers we have a duty to report to the police any suspicions that this practice is occurring in Australia or that a girl or woman is being sent to another country to have FGC performed. Child protection legislation is also relevant where suspicions relate to a child under the age of 16 years. If concerns remain that a child is at risk, health professionals are mandated to report this to the relevant authorities (refer to the *Female genital mutilation: information for Australian health professionals* booklet[2] for a list of state- and territory-based contacts and support).

WHO classifies FGC into three main types, as described below, with a fourth 'unclassified' category.[8]

- Type 1 refers to the partial or total removal of the clitoris and/or the prepuce.
- Type 2 refers to the partial or total removal of the clitoris and labia minora with or without excision of the labia majora.
- Type 3 refers to the narrowing of the vaginal orifice together with the creation of a covering seal by cutting and appositioning the labia minora and/or labia majora (with or without removal of the clitoris), which is known as infibulation.
- Type 4 refers to 'unclassified' practices and includes all other harmful procedures for nonmedical purposes, including pricking, piercing, incising, scraping or cauterisation.

There is a wide variation in the practice and therefore in the consequences of FGC. When performed in unsanitary conditions FGC can result in bleeding, infection and death. Although some women do not experience any problems that they attribute to FGC, there is a wide range of possible long-term complications as shown in the box on this page. Referral of women who have undergone FGC to specialised services may be required for the management of the listed complications. Early antenatal referral to a service specialising in the care of women with FGC is advised for pregnant women with Type 3 infibulation.

Women who have experienced FGC may be less likely to visit a GP or family planning clinic for a Pap test or to seek help for common conditions such as vulvovaginal candidiasis. Fear of genital examination can lead to the missed or late diagnosis of serious conditions such as cervical or other genital cancers. The role of the GP in caring for women with

LONG-TERM COMPLICATIONS OF FEMALE GENITAL CUTTING[2]

- Vulval scarring and pain
- Pelvic and urinary infection
- Obstructed menstrual and urinary flow
- Urinary and faecal fistulas
- Obstructed miscarriage and childbirth
- Vaginal and perineal damage at childbirth
- Sexual difficulties including apareunia and dyspareunia

THE GP'S ROLE IN RESPONDING TO REQUESTS FOR FEMALE GENITAL COSMETIC SURGERY FOR NONMEDICAL REASONS

- Explore why surgery is being considered and the expectations of surgical outcomes
- Carry out an examination with appropriate reassurance about normality and variability
- Consider directing women to pictures/websites depicting the normal variation of female external genitalia (see the box on the right of this page)
- Explain the risks associated with surgery, including the lack of evidence for improved satisfaction or enhanced sexual function
- Consider referral of the patient to a psychologist skilled in assessing and intervening in issues of body image, sexuality and relationships

FGC is to:

- provide sensitive, nonjudgmental care
- be aware of the varied appearance of the effects of FGC
- determine referral pathways for those requiring specialised care.

FEMALE GENITAL COSMETIC SURGERY

Female genital cosmetic surgery describes a wide variety of procedures. The discussion in this article is restricted to surgery of the external genitalia, including labial reduction, clitoral hood reduction and the less common clitoral repositioning for cosmetic purposes. These procedures have no medical benefits and should be distinguished from medically indicated genital surgical procedures for the correction of congenital anomalies or the repair of damaged tissue after childbirth, trauma (including FGC) or genital cancers.

It is likely that GPs will be increasingly asked to provide advice or generate referrals for genital cosmetic surgery resulting from anxiety about labial appearance (see the box on this page). Most labiaplasties in the UK have been performed on women between the ages of 16 and 35 years, although women in their 50s and older are increasingly requesting procedures to overcome the changes in genital appearance that occur as a natural part of ageing.[9]

Anxiety about labial appearance, in particular the concern that the labia minora protrude beyond the labia majora, appears to result from today's preference for pubic hair removal along with the airbrushed uniformity of pornographic imagery produced by the publishing industry. Removal of pubic hair reveals the normal variability of the external female genitalia while standardised pornographic depictions of the vulva and labia lead to abnormal perceptions about how the genitalia 'should' look. A 2009 Dutch survey found that almost half of the participants considered genital appearance to be important while one in seven thought their labia minora were abnormal.[10]

An important role of the GP is to provide reassurance about the variability of normal female genitalia, especially in the context of the expected changes that occur with age. It is common in the family planning setting for women of all ages to ask whether 'everything looks normal' at the conclusion of a Pap test. Although most women have not had the opportunity to observe the variability of labial size and shape, GPs are in a privileged position to provide appropriate reassurance based on experience.

Measurements from 50 premenopausal women undergoing gynaecological surgery not involving the external genitalia found that the width of the labia minora ranged from 7 to 50 mm with a mean of 21.8 mm while clitoral length was documented between 5 mm and 35 mm with a mean of 19.1 mm.[11] Developmental changes in adolescence can result in unilateral labial enlargement and the inner labia being longer than the outer labia. These changes are usually transient and will realign as the young woman reaches adulthood. Loss of collagen and fat and reduced pubic hair after menopause can result in a change in the vulval appearance and make the labia minora appear enlarged in comparison with the labia majora.[9] A list of resources depicting the variability of female genitalia, which may be helpful for women, is provided in the box on this page.

RESOURCES DEPICTING THE VARIABILITY OF FEMALE GENITALIA

Women considering cosmetic surgery may find the following resources helpful:

- Blank J, ed. Femalia. San Francisco, CA: Last Gasp, 2011.
- The-Clitoris.com website. Available online at: http://www.the-clitoris.com/n_html/clitoral_and_labial_size.htm
- Petals, colour poster. Available online to purchase at: http://nickkarras.com/Color_Poster.html

When considering referral for cosmetic genital surgery it is important to inform the patient about the procedure as well as its potential risks. Surgical methods include longitudinal trimming of the labial edges, Z-incision or wedge resection of the labia followed by suturing of the labial edge. The clitoral hood may be reduced at the same time as it can appear more prominent after reduction of the labia.

Risks of the procedure include bleeding, infection, wound breakdown, scar tissue formation, chronic pain and reduced sexual function. Complication rates are documented to be up to 30%.[9] Reoperation rates in the UK have been quoted as being between 2.9% and 7% for reasons including wound dehiscence and dissatisfaction with appearance.[9] It is important for women to be aware that there is

KEY POINTS

- GPs are increasingly likely to see women who have experienced female genital cutting (FGC) because of the rising numbers of migrants settling in Australia from countries where this traditional cultural practice is prevalent.
- The GP's role is to provide sensitive, nonjudgmental care to women living with FGC, to be aware of the varied appearance of the effects of FGC and to determine referral pathways for those requiring specialised care.
- GPs can expect to see increasing numbers of women requesting genital cosmetic surgery, in particular labial reduction surgery for nonmedical purposes.
- GPs are in a good position to allay women's concerns about the appearance of their labia to prevent unnecessary surgical intervention.

no evidence that surgery in women with normal genitalia improves satisfaction with genital appearance or enhances sexual function or pleasure. Few data are available on the long-term risks of the procedure.

GPs should also be aware of the possibility of body dysmorphic syndrome in women with severe distress about their genital appearance. Referral of these women to a psychologist or psychiatrist with expertise in this complex area may be required.

The area of female genital cosmetic surgery is contentious and largely unregulated. The Australian Federation of Medical Women has released a position statement opposing the promotion and use of surgical products and techniques that make unproven claims of enhancing female sexual satisfaction and/or attractiveness.[12] As a community we need to address why women and girls are increasingly anxious about their genital appearance. As clinicians we need to be wary of referring women for surgery that is not medically necessary and may have potential for harm.

CONCLUSION

As migration increases from countries where FGC is prevalent, GPs are increasingly likely to provide care for women who have experienced this practice. Awareness and recognition of the variability of FGC is essential to ensure the provision of sensitive and nonjudgmental care and appropriate referral for its long-term complications. GPs also have a role, as do all community members, in identifying girls who are potentially at risk of FGC.

GPs are also likely to encounter an increase in requests for advice and referral for female genital cosmetic surgery. The profession is uniquely placed to allay women's anxiety about their labial appearance to prevent unnecessary surgical intervention for those with normal genitalia. MT

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