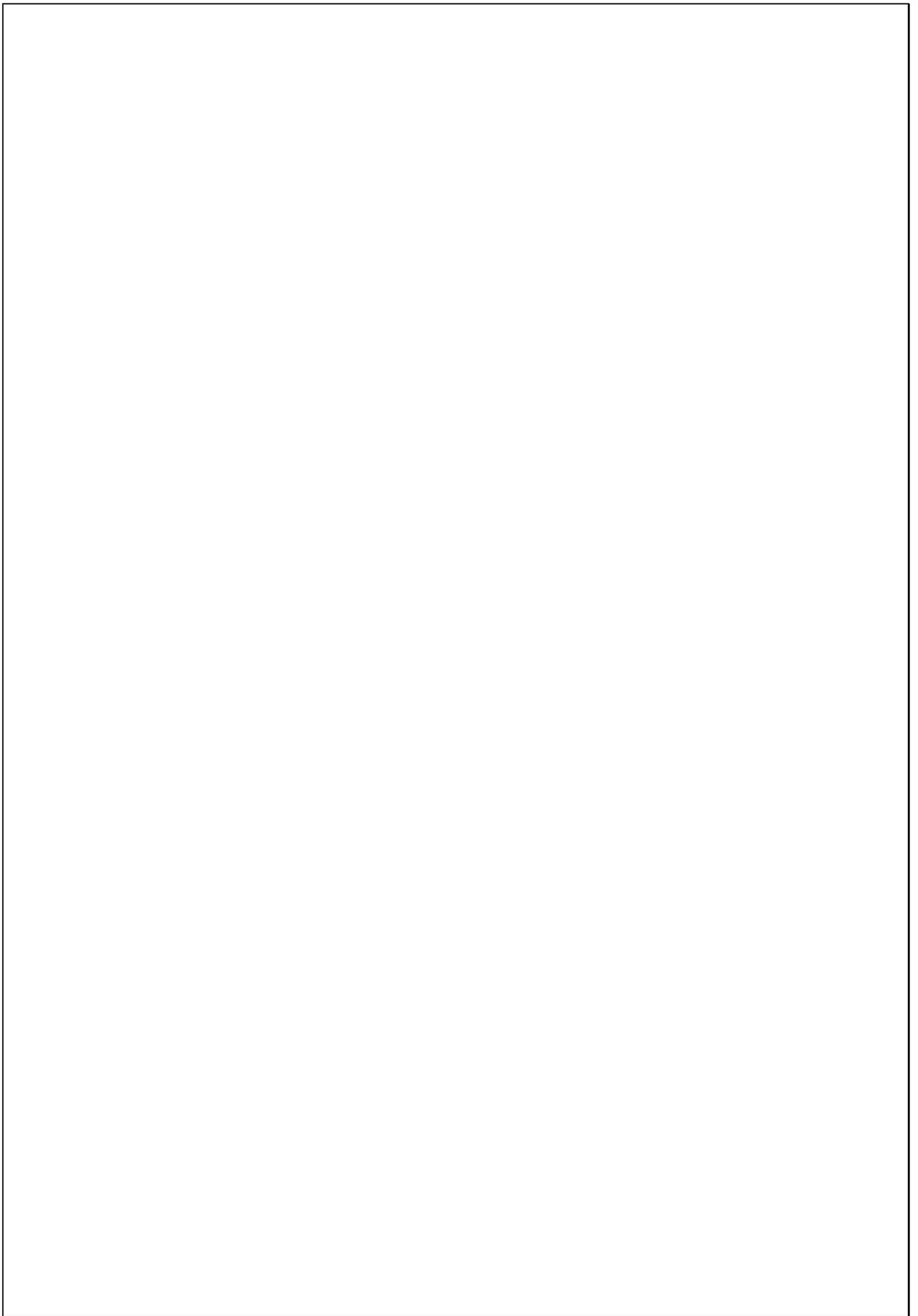




# University of Nigeria

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## COMPLICATIONS OF FEMALE CIRCUMCISION IN NIGERIAN IGBOS

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### Summary

An analysis is made of 43 children and 15 adult female patients who presented with post-circumcision complications at the University of Nigeria Teaching Hospital, Enugu, between January 1973 and December 1980; 57 patients had been circumcised within 21 days of birth and one patient in the seventh month of her first pregnancy. Age of presentation varied with the severity of the symptoms: 21 children and 11 adults presented with varying degrees of labial occlusion, while 9 children and 4 adults had implantation dermoids. Urinary retention was the problem in 12 children and one adult.

FEMALE circumcision dates well back into history and probably originated as an initiation ceremony of young girls into womanhood. A Greek papyrus dated 163 BC made reference to the ritual (Mustafa, 1966).

It is performed more widely than is generally recognised, and no continent is exempt (Bella, 1980). In Africa, it is very commonly practised, and the custom has been sustained by traditional beliefs. It has been justified on aesthetic grounds by Abyssinians and Hottentots (Hathout, 1963), as an insurance towards perpetual virginity by the Russian Skoptozy (Mustafa, 1966) and as a symbol of sexual identification and fertility by some West African tribes (Bella, 1980). Among the Igbos of Nigeria, circumcision is believed to make women more feminine and more attractive to men, to promote chastity by attenuating sexual desire, and to encourage cleanliness by reducing vaginal discharge. The pain experienced when circumcision is performed

in the pregnant mother is claimed to prepare her for childbirth.

Nearly all the published literature on female circumcision concerns infibulation as practised in the Sudan and Egypt. This operation, which is unknown among the Nigerian Igbos, involves the excision of the clitoris, the labia minora and majora, with the virtual obliteration of the introitus. In Igboland, the more limited procedure of 'simple excision' is employed. In 'simple excision' called 'Ibe-Ugwu', the clitoris or labia minora or both are removed. In certain areas like Ezeagu and Idemili, the emphasis is on the removal of the labia minora while in others like Orlu and Nkwere, it is on the excision of the clitoris. The Sunna circumcision, in which only the prepuce of the clitoris is excised, is rarely practised among the Igbos. Most female Igbos, like the males, are circumcised 7 to 21 days after birth, usually after the umbilical stump has separated, but in a few

areas like Abakaliki, the ritual is celebrated at puberty, while in others like Ogbaru, the operation is carried out during the first month of the first pregnancy.

#### PATIENTS

Records were obtained for analysis of 58 patients seen with post-circumcision complications at the University of Nigeria Teaching Hospital (UNTH) Enugu between January 1973 and December 1980. There were 43 patients aged 12 years and under who attended the Paediatric Surgical Unit and 15 patients aged between 16 years and 24 years who were seen at the Gynaecological Unit.

#### Surgical technique

In all patients the operation had been performed by medically unqualified persons. Generally, the surgeon is an elderly female or male who is well known to the villagers and who has acquired the skill through many years of apprenticeship. Mature and experienced female relations assist at operation by forcibly holding down the victim in the lithotomy position. The traditional instrument is a sharp razor called 'Aguba'. The operator picks up the clitoris and labia minora between forefinger and thumb, and starting at the base, cuts swiftly down each side of the organs, removing both clitoris and labia minora en bloc. Neither anaesthesia nor asepsis is considered. As the victim struggles in pain, the extent of the surgery becomes dictated by chance and occasionally the incision inadvertently involves adjoining structures such as the urethra, vagina or rectum. Haemostasis is often successfully achieved by the application of a paste or poultice consisting of a crushed medicinal root prepared in a palm oil base.

#### RESULTS

##### Children

Table I shows the complications encountered in the paediatric patients: 21 had labial fusion; 13 had partial fusion in which only the anterior one third to half of the labia were fused and 8 had complete fusion of the entire length of the labia (Fig. 1).

Children with complete labial fusion presented with urinary retention, with usually only a small opening from which urine dribbled. At operation

TABLE I  
*Complications in children*

Complication	No. of patients	Mean age at presentation
Haemorrhage	2	10 days
Septicaemia	1	10 days
Urinary infection	2	10 days
Tetanus	1	20 days
<i>Labial fusion</i>	21	
Complete	8	10 months
Partial	13	5 years
<i>Urinary retention</i>	12	
Meatal obstruction	3	4 weeks
Complete labial fusion	8	10 months
Urethral stricture	1	1 year
Recto-vaginal fistula	1	3 years
Implantation dermoid	9	5 years
Introital stenosis	2	11 years

a probe was inserted through this hole and directed to the midline of the fused labia; the scar tissue was divided over the probe to part the halves of the labia. Scar tissue was excised from the edges and the latter were re-epithelialised. The external urethral meatus was often undisturbed underneath the fused labia. Patients with partial fusion were treated in a similar way but they presented at a later age as they rarely had urinary problems.

Implantation dermoid (Fig. 2) occurred in nine of the paediatric patients. These children presented about five years after circumcision, and the problem was cosmetic and psychological as the parents were worried about the ambiguous

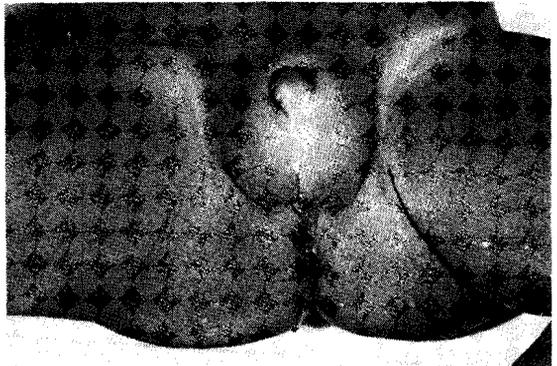


FIG. 1

Complete labial fusion in a 10-month old baby. Note urine escaping from a tiny hole in the midline.

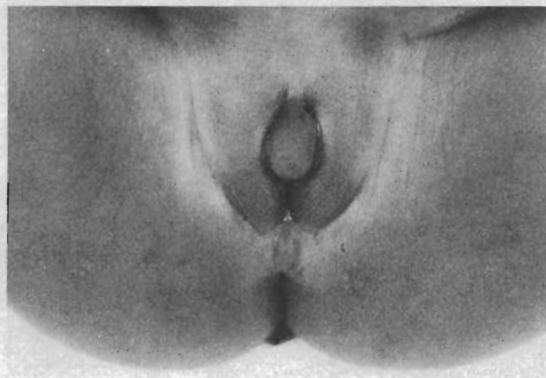


FIG. 2

A five-year-old child with an implantation dermoid at the area of the amputated clitoris.

appearance of the external genitalia. The dermoids are situated at the area of the amputated clitoris, and histologically are tumours formed from epidermoid cells which are buried under the dermis or subcutaneous tissue. Simple excision is the treatment.

Three patients with meatal stenosis presented with urinary retention and painful micturition. These were usually due to meatitis or the presence of a skin scab covering the meatus. Removal of the scab and the administration of antibiotics relieved the symptoms.

One of the 12 patients with urinary retention had a urethral stricture and she was treated by serial bouginage. Patients with introital scarring or stenosis (Fig. 3) presented years after circumcision with dysmenorrhoea. Scar tissue was excised and epithelialisation achieved.

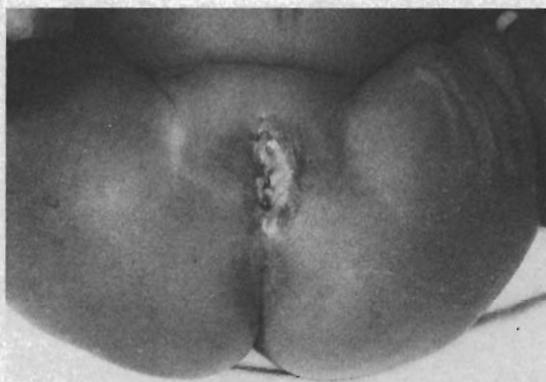


FIG. 3

Marked introital scarring and stenosis.

The three-year-old patient with a recto-vaginal fistula was a case of inadvertent excision of the posterior wall of the vagina with the anterior wall of the rectum during circumcision. A large rent formed the communication between the rectum, vagina, and the exterior. A colostomy was performed to divert faeces from the area and aid pre-operative recto-colonic cleansing. After the repair healed the colostomy was closed.

### Adults

The ages of the 15 adult patients at referral to the gynaecological clinic ranged between 16 and 24 years; 11 presented with introital occlusion, the degree varying from complete labial fusion with a minute midline opening near the posterior margin of the introitus for the escape of urine and menstrual blood in one case, to partial vulval stenosis. Superficial dyspareunia and inadequate vaginal penetration at coitus were the most frequent complaints and were present in nine patients (Table II). Six patients complained, in addition, of primary infertility, and four presented with implantation dermoids around the clitoroidal stump. These epidermoid cysts were confirmed histologically on excision.

TABLE II

*Presenting complaints and clinical findings in 15 adults*

Complaints	No. of patients (n = 15)	%
Dyspareunia and inadequate penetration	9	60
Infertility	6	40
Vulval lump	4	26.7
Poor urinary stream	2	13.3
Prolonged labour	2	13.3
<i>Clinical findings</i>		
Complete labial fusion	1	6.7
Partial vulval stenosis	10	66.6
Implantation dermoid	4	26.7
<b>Total</b>	<b>15</b>	<b>100</b>

In our experience, most circumcised women require elective episiotomy at their first delivery. An 'anterior episiotomy' may also be necessary to avoid the inevitable tear of the circumcision scar. Two of the patients in this study presented, for the first time, with prolonged labour due to 'post-circumcision vulval stenosis'. In the absence of fetopelvic disproportion, vaginal delivery was achieved in both patients, aided by a generous episiotomy.

#### COMMENT

The practice of female circumcision, although reportedly on the decline, is still widespread and carries with it a high morbidity and occasionally mortality, especially among children. Clinicians everywhere should, therefore, be aware of complications of the custom.

Early complications, such as haemorrhage, septicaemia, and tetanus were rarely encountered in this series, probably because most of the patients do not survive to reach hospital.

Post-circumcision labial fusion, which accounted for nearly half of all the complications in childhood, is to be distinguished from infantile labial agglutination due to vulvo-vaginitis. The latter does not require operation and is readily treated by local application of oestrogen cream.

Post-circumcision external genital deformities may simulate 'intersex' (Iregbulem, 1980). An unfortunate situation may therefore arise where a male 'intersex' is circumcised, the stunted phallus being amputated in the mistaken notion

that the child is a female. This underlines the need for full investigation of patients.

Introital narrowing of varying degree, secondary to labial fusion and vulval stenosis, was responsible for the great majority of presenting complaints in the adult. Implantation dermoids were common complications in both children and adults. These cysts, reported as rare complications of infibulation (Hathout, 1963), were also found to be quite common in the Sudan (Mustafa, 1966). Other complications of female circumcision which we did not encounter in this study include arthritis (Hall, 1963), vaginal calculi (Onuigbo and Twomey, 1974), cryptomenorrhoea, keloid scars and chronic bacterial or chemical vaginitis. The cultural connotations of female circumcision in the Igbo society make objective evaluation of the psychological implications of the custom difficult.

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